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ABSTRACT

Each issue in the year 2000 edition of the Australian Transcultural Mental Health Network (ATMHN) newsletter represents a theme crucial to mental health practitioners. The articles in Winter 2000 are the result of the national Suicide Prevention in Immigrant Populations Conference and include detailed analyses on suicide trends in diverse cultural and linguistic communities, suicide bereavement in the very young, and the challenges of providing an effective transcultural mental health services in remote Australia. Spring 2000 features articles on cross cultural mental health training programs for General Practitioners. Summer 2000 discusses obstacles to effective mental health promotion, prevention, and education. Autumn 2000 presents a report on the cultural competence in Victorian Child and Adolescent Mental Health Services. Each issue contains reports on current ATMHN-funded projects. (Contains 12 tables and 73 references.) (JDM)

Synergy: The Australian Transcultural
Mental Health Network Newsletter, 2000

Sandee Baldwin, Editor

Winter-Fall 2000

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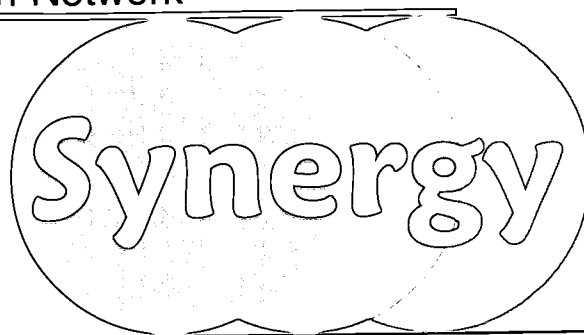
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Winter 2000

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Dear Reader



I welcome this second opportunity to contribute to *Synergy* - the newsletter of the Australian Transcultural Mental Health Network (ATMHN).

Since I had the pleasure of contributing to the first edition in Spring 1999, *Synergy* has rapidly evolved to become an extremely informative publication with an ever-expanding distribution list. Now, almost 4,500 readers subscribe to *Synergy* and feedback received by the editors is very positive.

The current, Winter 2000 edition, will be the first *Synergy* to focus on a specific subject and this edition will deal with the issue of suicide. In future editions *Synergy* plans to look at primary health care, depression and the mental health of diverse cultural and linguistic communities based in rural Australia.

Suicide is one of the great tragedies that affects many Australians far too often and it touches people throughout our society. Across the ages, economic status and ethnic grouping suicide has devastated individuals, families and communities. For this reason I was very pleased that the Government was able to build on the work of the National Youth Suicide Prevention Strategy with a new program. The 1999 Federal Budget committed \$39.2 million over four years to promote suicide prevention across the age span. The funds will be spent on a mix of grass-roots programs as well as national activities. In the years ahead I expect there will be many occasions when both research and specific programs on suicide prevention with diverse cultural communities will be funded. Please call the contacts provided on page 16 of *Synergy* for more information on this new Commonwealth Government initiative.

Another priority of the Government has been to address the inequality and access to health services for Australians who live in the rural and remote parts of our country. As you are probably aware, the 2000 Budget provides great news for rural Australia with over \$500 million being directed to rural health initiatives over the next few years. The money will provide real improvements for rural Australians and will help improve the reach of mental health services. Enhancing the capacity of primary health workers to deal with mental illness, within mainstream settings, will also be a priority. The ATMHN should play an important role in this process, advising service providers on how best the mental health needs of rural Australians from diverse cultural and linguistic backgrounds can be met.

I hope you find the current edition of *Synergy* informative and helpful. The articles are the result of my Department's funding of the recent national *Suicide Prevention in Immigrant Populations Conference* and include detailed analyses by leading experts on suicide trends in diverse cultural and linguistic communities, suicide bereavement in the very young, and the challenges of providing an effective transcultural mental health service in remote Australia. I continue to commend to you the work of the ATMHN and invite you to maintain your commitment to the issues and agenda of improving the mental health of all Australians.

Michael Wooldridge

Dr Michael Wooldridge
Minister for Health and Aged Care



Suicide Prevention in Immigrant Populations Across Australia: Setting the Agenda for the 21st Century

The Fifth NSW Transcultural Mental Health Centre Conference, Suicide Prevention in Immigrant Populations Across Australia: Setting the Agenda for the 21st Century, was held in Sydney recently. The Conference aimed to provide those attending with an opportunity to exchange ideas, knowledge and strategies to assist with the formation of strategic directions and recommendations in the area of suicide prevention for immigrant communities in policy research and clinical practice.

This edition of Synergy includes five of the papers presented at the conference. The ATMHN hopes this edition of Synergy will be a useful resource for all those concerned with the well-being of Australians from culturally and linguistically diverse backgrounds.

Synergy would like to thank the contributing authors for their generosity and commitment to the issues surrounding suicide in migrant populations.

OUTGROWING THE 'E' WORD

The next step towards racial harmony should be to drop the word 'ethnic', writes Stephen Kerkyasharian, chairman of the Ethnic Affairs Commission of NSW.

An inquiry by a committee of the Upper House of the NSW Parliament is trying to find out if ethnics still want to be called ethnics. The legislation being examined would change the name of the Ethnic Affairs Commission of NSW to a Community Relations Commission.

Detractors of the legislation claim that changing the name from ethnic affairs to community relations is weakening multiculturalism. Mr Kerkyasharian disagrees stating that the bill effectively prescribes the essence of a multicultural society and creates a Community Relations Commission to reinforce the notion of equality, acceptance of cultural diversity and unity of commitment to Australia.

Sydney Morning Herald 23/5/00

CORROBOREE 2000

An estimated 250,000 Australians crossed Sydney Harbour Bridge on May 26th, the culmination of the formal decade-long reconciliation process.

Corroborree marches have also been held in Brisbane and Adelaide.

Pictured below is the Director General of the NSW Health Department, Mick Reid, leading a large contingent of NSW Health workers.



NATIONAL SUICIDE PREVENTION STRATEGY

The Mental Health and Special Programs Branch in the Department of Health and Aged Care has been administering the implementation of the new National Suicide Prevention Strategy. As you will note from Dr Wooldridge's Synergy letter, there are likely to be many opportunities to develop suicide prevention programs for Australia's diverse cultural and linguistic communities under this initiative – more in the next edition of Synergy!

Prescription Levels for Anti-Depressants Increase in Queensland

Queensland General Practitioners are prescribing anti-depressants at twice the level of 6 years ago. More than 1.5 million prescriptions were issued in Queensland in the last financial year. Only in Tasmania and South Australia are anti-depressants more readily dispensed.

The medical profession says more people are suffering depression and General Practitioners' awareness of the problem has grown. The prevalence of mental illness does not vary greatly between metropolitan and regional areas.

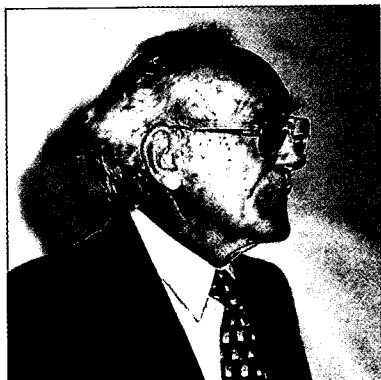
The Courier Mail

Suicide in Immigrant Populations in Australia: The Last Four Decades

Emeritus Professor Peter Burvill
University of Western Australia

It is almost 70 years since Ödegaard (1932) began the first scientific investigation of the association of immigration and mental disorder. Since then much has been written on this subject. The literature regarding suicide is even more voluminous.

By contrast there is a relative paucity of published work on suicide in immigrants, and even less on attempted suicide.



Following a review of the literature, Barraclough (1987) concluded that internal migration is clearly associated with an increased suicide risk. Research of suicide in immigrants in Hong Kong (Yap, 1958), United States of America (Sainsbury & Barraclough, 1968), Australia (Whitlock, 1971; Burvill, McCall, Stenhouse & Reid, 1973a; Burvill, Woodings, Stenhouse & McCall, 1982a) and Canada (Kliewer & Ward, 1988) have shown higher suicide rates among immigrants than those of the population from which they originated, but a large differential in both rates and methods of suicide among individual immigrant groups. However Kliewer and Ward (1988) indicated that immigration does not necessarily increase the risk of suicide, and that in Canada immigrants from countries where the suicide rates were higher than that of the Canadian-born tended to experience a decrease in suicide risk.

I have been asked to survey the literature on suicide in immigrant populations in Australia during the past four decades. Apart from a brief mention of differential suicide methods in W.A. in immigrants compared with the Australian-born by Burvill (1970), the earliest literature on the subject for the whole of Australia were by Whitlock (1971), Lester (1972) and Burvill et al. (1973a). Whitlock (1971) analysed Australian suicide data for the three years 1965-67 and speculated at length on the various sociological factors involved. Lester (1972) wrote a letter to the editor of the Medical Journal of Australia regarding the high correlation between suicide rates of immigrants in Australia and that in their country of birth (COB).

Burvill et al. (1973a) mainly focused on the relationship between the mortality rates from suicide, motor vehicle accidents and other forms of violent death among immigrants in Australia. They showed that for males, but not females, those immigrant groups who had high suicide rates also had high rates of death from motor vehicle accidents and other forms of violent death, and vice versa for those countries with low rates. All these papers covered the period 1961-70.

These early papers mainly referred to immigrants from the United Kingdom and Europe, and all showed higher rates in immigrants. It is important when viewing these higher rates to examine whether or not the quoted rates are standardised for age and sex, as non age standardised rates are often higher. For example Whitlock (1971) quoted non-standardised rates for immigrant men and women of 27.7 and 15.0 per 100,000 compared with the Australian-born of 16.1 and 10.0 for the 3 years 1965-67, whereas the age standardised suicide rates for the 5 years 1961-66 quoted by Burvill et al. (1973a) were considerably lower at 18.2 male and 9.4 female in immigrants and 16.3 and 8.4 respectively in the Australian-born.

Continued Overleaf

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It is similarly important when considering suicide rates in immigrants to focus on rates specific for COB as well as gender. There is a very large differential in rates between individual countries, e.g. the data of age standardised rates for the ten years 1961-70 showed an eightfold difference for men and a fourteenfold difference for women in age standardised rates of immigrants from Europe (Burvill et al. 1982a) (Table 1).

Generally speaking, those immigrants from Northern and Eastern European countries had significantly higher rates than the Australian-born, whereas those from the Southern European countries were significantly lower. Those from the English speaking countries were not significantly different. Later data from 1981-90 showed significantly lower rates in males but not females in those from Asian countries and in both sexes in those from the Middle East (Burvill, 1998) (Table 2). Similar patterns were found by Morell, Taylor, Slaytor and Ford (1999) for the whole of New South Wales for the years 1985-94.

Data quoted for the 12 years 1979-90 in Tables 3-6 came from previously unpublished data. Those years included a higher number of suicides in non-European immigrants than the earlier data from the 1960s, in keeping with the higher number and more diverse source of immigrants to Australia in the last two decades. The population of Europe contains widely diverse countries and national groups, with a large differential in suicide rates (Ruzicka, 1976). The same applies to Asia. It is not as easy to get as accurate suicide data for Asian countries for comparison purposes, and the generally lower suicide rates of Asian immigrants makes statistical analysis difficult.

Table 3 lists the age standardised rates of Asian immigrants during 1979-80. All these national groups had less than 50 suicides in either sex during those 12 years. Of the 11 Asian countries listed, all but Korea had very low male rates. By contrast five of the countries had female rates consistently higher than the Australian-born. The small numbers involved may have made these quoted rates unreliable.

METHODS OF SUICIDE

Methods of suicide differ considerably between countries, and tend to change somewhat over time, for example suicide methods in England and Wales have long been very different to those in Australia, especially in males, even though the two countries are culturally similar. Data show that the suicide methods used by immigrants approached more closely those of the Australian-born the longer they had lived in Australia (Burvill et al., 1982a). The changes in methods used were greatest in those immigrant groups coming from countries with a language and culture more akin with the Australian-born, whereas those from countries with quite different cultures and languages only partly approached, in time, the Australian methods.

TABLE 1

AGE STANDARDISED SUICIDE RATES BY COB GROUPS 1962-71

| Country of birth | Rates in Australia | | Statistical Significance | |
|------------------|--------------------|------|--------------------------|------|
| | M | F | M | F |
| Scandinavia | 39.7 | 27.0 | 0.01 | 0.01 |
| Hungary | 38.0 | 31.1 | 0.01 | 0.01 |
| Austria | 36.6 | 25.9 | 0.01 | 0.01 |
| Czechoslovakia | 26.2 | 22.8 | 0.01 | 0.01 |
| Germany | 25.0 | 12.2 | 0.05 | 0.01 |
| Poland | 23.3 | 15.0 | 0.01 | 0.05 |
| Yugoslavia | 20.7 | 11.2 | 0.05 | NS |
| New Zealand | 20.5 | 15.9 | NS | 0.1 |
| Wales | 19.5 | 9.2 | NS | NS |
| Ireland | 17.7 | 7.6 | NS | NS |
| Scotland | 17.3 | 10.1 | NS | NS |
| England | 16.9 | 9.0 | NS | NS |
| Australia | 16.3 | 8.8 | - | - |
| Netherlands | 12.9 | 5.8 | NS | NS |
| Italy | 9.4 | 3.5 | 0.01 | 0.01 |
| Greece | 6.1 | 2.8 | 0.01 | 0.01 |
| Malta | 4.9 | 2.2 | 0.01 | 0.01 |

TABLE 2

AGE STANDARDISED SUICIDE RATES BY COB GROUPS 1981-90

| Country of birth | No of Suicides | ASR Statistical Significance | |
|------------------|----------------|------------------------------|--------|
| | | Male | Female |
| Australia | 12556 | 25.4 | - |
| Europe | 1937 | 26.1 | NS |
| UK and Eire | 1724 | 23.7 | NS |
| Asia | 259 | 14.6 | 0.001 |
| Middle East | 102 | 13.7 | 0.001 |
| Australia | 3753 | 7.2 | - |
| Europe | 652 | 9.6 | 0.001 |
| UK and Eire | 481 | 6.9 | NS |
| Asia | 128 | 7.1 | NS |
| Middle East | 22 | 3.4 | 0.01 |

TABLE 3

AGE STANDARDISED SUICIDE RATES ASIAN BORN 1979-90*

| Country of birth | ASR | Ratio ASR to Australian born | ASR | Ratio ASR to Australian born | M:F |
|------------------|------|------------------------------|------|------------------------------|-----|
| | | | Male | Female | |
| Korea | 29.6 | 1.16 | 10.6 | 1.48 | 2.7 |
| Singapore | 19.2 | 0.76 | 4.1 | 0.58 | 4.7 |
| India | 17.4 | 0.69 | 4.1 | 0.58 | 4.7 |
| China | 16.9 | 0.66 | 10.6 | 1.49 | 1.6 |
| Hong Kong | 15.4 | 0.61 | 12.2 | 1.71 | 1.3 |
| Vietnam | 12.7 | 0.5 | 2.6 | 0.36 | 4.9 |
| Malaysia | 12.4 | 0.49 | 6.7 | 0.93 | 1.9 |
| Japan | 11.5 | 0.45 | 14.3 | 2.01 | 0.8 |
| Sri Lanka | 10.1 | 0.4 | 3.9 | 0.55 | 2.6 |
| Indonesia | 9.4 | 0.37 | 18.6 | 2.62 | 0.5 |
| Philippines | 4.0 | 0.16 | 2.8 | 0.39 | 1.4 |

* Unpublished data

Project Report

"Youth At Risk of Deliberate Self Harm" YARDS Project

Reducing Repeated Deliberate Self Harm (DSH) Among Youth:
The Impact of Service Development and Enhanced Clinical Development

Project Manager: Dr Margaret Tobin

The YARDS Project commenced in January 1997 and continued for two years.

Conducted by South Eastern Sydney Area Health Service and Northern Rivers Area Health Service, YARDS aimed to enhance mental health care for young people with deliberate self harm (DSH) both in service performance and specific clinical treatment. The project also aimed to assess the impact of such enhancement on mental health outcomes.

South Eastern Sydney Area Health Service (SESAHS) and Northern Rivers Area Health Service (NRAHS) operate a range of child/adolescent and adult mental health services covering both urban and rural settings. These include inner city districts with high numbers of homeless youth, beach cultures with high drug and alcohol abuse rates, and districts with high NESB groups. There is a wide variation in socio-demographic indices.

Suicide is responsible for 22% of all deaths among young people in Australia. Rates among males are approximately 21 per 100 000 per year and are 5 per 100 000 per year for females. For every male suicide there are 30 to 50 attempted suicides and for every female suicide, between 150 to 300 attempts. The rate of completed suicides has tripled since the 1960's.

From a clinical perspective, 10% of Deliberate Self Harm (DSH) clients are likely to reattempt within three months of an initial attempt (Spirito et al., 1994). However, studies have shown that fewer than 50% of clients are referred for follow up treatment (Nirui, 1995; Piacentini et al., 1995) and of those who receive an appointment, up to 75% may not attend (Cantor, 1994).

A number of procedures and processes have been reported to improve the treatment of self harming clients in clinical settings. These have included; (1) the use of a 'Green Card' system of referral intended to enhance attendance at follow up (Morgan et al., 1993), (2) the use of standardised measures in the assessment of both risk and protective factors at the first contact point (Cantor, 1994), the use of standardised measures of health outcomes (Beck, 1993), and use of systematised clinical interventions.

The NSW Mental Health Expert Working Party (Scanlon, 1995) cited a number of measures as worthy of consideration in managing those making suicide attempts. These include; (1) establishing comprehensive services for the identification, management, treatment and follow-up; (2) implementing protocols and procedures for the management of people presenting to the health system following a suicide attempt, including the 28 days following discharge; (3) training health staff in assessment, treatment and management of people presenting after a suicide attempt and (4) addressing health staff attitudes towards people presenting following a suicide attempt.

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Promoting Cultural Responsiveness in Psychiatric Disability Support Services

Psychiatric Disability Support Services (PDSS) provide a range of community based mental health rehabilitation services to people with mental illness across Victoria. Two hundred and thirty one services operate across the state providing day programs, supported housing, home based outreach, residential rehabilitation, with a focus on suicide prevention and planned respite. Receiving 12% of the total mental health budget, they are a key component of the provision of Victorian community based mental health services.

VICSERV, the peak body representing PDSS in Victoria, is nearing completion of a project designed to enhance the capacity of PDSS to respond to the requirements of culturally and linguistically diverse service users.

As part of this project a literature review has been undertaken to ascertain what policies, publications and program evaluations exist which inform culturally responsive practices in mental health services.

A plethora of material to inform was found. Specifically, 29 Australian publications released since 1995 have been identified. There have been developed by various government departments – Commonwealth (5), Victoria (7),

NSW (1), Queensland (1), the Transcultural Mental Health Centres/Networks (8), and other organisations (7). They identify a common set of principles, practices and quality frameworks that underpin culturally responsive service provision.

VICSERV did not want to “re-invent the wheel” and so has been challenged to think of a different strategy; one that goes the next step and explores “how” to implement these principles, practices and frameworks.

The result has been to focus on the development of:

1. A framework to assess “how” culturally responsive the organisation is.
2. An implementation strategy that describes “what” needs to be done to facilitate cultural responsiveness.
3. A change strategy to determine “who” is responsible for doing what aspects of the implementation strategy.

It is expected that this set of tools will be available in August 2000. This project was funded by the Department of Human Services – Mental Health Branch.

For further information, please contact
Ro Marks at VICSERV

One saturday in summertime I heard a little cry
And turned around to see a fellow punching at the sky
I cried out to this gentleman “please sir, tell me why
On saturday in summertime you’re punching at the sky?”
“I do not know,” he cried to me “I’m normally so shy;
But saturdays in summertime I like to punch the sky.”



Leunig

Welcome to the first ATMHN Management Unit update. The ATMHN Management Unit, which recently moved into new premises in Sydney's Cumberland Hospital, manages and coordinates the work of the ATMHN across Australia. We are the faces you see and the people you talk to when you contact the ATMHN, order recent Network publications or visit our stall at Conferences. In each edition of Synergy we will be letting readers know what's happening with the ATMHN and how to be more involved.

CONFERENCES

As well as holding the first ATMHN Advisory Group for the year, the early months of 2000 have seen the ATMHN attend three major conferences around Australia.

In March we attended "Share the Care", the International Conference of Carers Australia, in Brisbane and the 5th NSW Transcultural Mental Health Centre Conference: "Suicide Prevention in Immigrant Populations across Australia: Setting the Agenda for the 21st Century" in Sydney. This edition of Synergy highlights a range of papers presented at this conference.

April saw the work of the ATMHN highlighted at the 35th Royal Australian & New Zealand College of Psychiatrists Congress in Adelaide where the conference theme, "Looking Outward: Culture, Creativity and Psychiatry" attracted eminent international speakers and over 700 international and Australian delegates. See the report by conference convenor and ATMHN Advisory Group representative Professor Rob Barrett, elsewhere in Synergy.

Our thanks go to the organisers of these conferences for their support in taking the ATMHN to these meetings. We appreciate the opportunity to meet new people working in transcultural mental health and to share the activities of the ATMHN with new and old friends. Are you holding a conference or event where people may be interested in hearing about the work of the ATMHN? Contact us, as a representative of the Management Unit or a local ATMHN representative may be keen to be involved.

ADELAIDE FORUM

On November 17 and 18, 2000 the ATMHN will sponsor a forum on transcultural mental health to be held in Adelaide. This will be organised by SA NESBWEB and will focus heavily on consumer and carer issues. We hope to see many Synergy readers at this important SA event. See page 20 for more information and contact details.

'DIVERSITY IN HEALTH'

We are sure to be meeting and hearing from many of you at "Diversity in Health: Sharing Global Perspectives", in Sydney on May 28-30, 2001. This important conference, which incorporates the ATMHN 2nd National Conference, will be a great opportunity for workers dealing with mental health issues in multicultural communities to showcase their work for a national and international audience.

Submission of abstracts for "Diversity in Health" closes on October 31, 2000. The Call for Abstracts is included with this edition of Synergy. If you didn't receive it or you would like extra copies of the Call for Abstracts or to know more about "Diversity in Health" visit the conference web site at www.diveristy.tmhc.nsw.gov/diversity - or contact the Diversity in Health Conference Secretariat on (02) 9518 9580 or e-mail diversity@pharmaevents.com.au We look forward to seeing you in Sydney next year!

BOOK LAUNCH

The ATMHN was delighted to use the NSW TMHC Suicide Prevention Conference to launch its most recent publication, "Mentalhealth consumerparticipation in a culturally diverse society", by Andrew Sozomenou, Penny Mitchell, Maureen Fitzgerald, Abd Malak and Derrick Silove. We were honoured to have Dr Tim Smyth, former Deputy Director General of NSW Health, launch the monograph at a reception chaired by Ms Janet Meagher (pictured), AM, Coordinator of NSW Consumer Advisory Group - Mental Health Inc. This publication is available from the ATMHN Management Unit on (02)9840 3333.



ATMHN PROJECTS

Commonwealth Report

The Mental Health and Special Programs Branch in the Department of Health and Aged Care has been busily finalising contracts for a range of national transcultural mental health projects being undertaken with the assistance of Commonwealth funds from the National Mental Health Strategy. Below, is a summary of the projects now commencing.

TASMANIA

TRANSCULTURAL MENTAL HEALTH PROJECT

Tasmania has received funding to undertake a transcultural mental health project which will be administered from the Migrant Resource Centre (based in Launceston, Northern Tasmania). The project involves reinvigorating the Tasmanian transcultural mental health network, attempting to build a sustainable base for the network, and improving access to information about mental health services for people from culturally and linguistically diverse backgrounds, in particular, for those living in the north and north west of Tasmania. The appointment of a part time mental health professional will assist migrant services and communities to access mental health services through providing education and information on referral processes and practices. The project officer will be responsible for facilitating and conducting community education and information sessions for migrants and supporting workers involved in caring for migrant mental health consumers and carers.

Karin Le
Migrant Resource Centre, Launceston
phone: (03) 6331 2300
mrcltn2@tassie.net.au

SOUTH AUSTRALIA

RECIPROCITY IN EDUCATION: A COMMUNITY-BASED MODEL FOR CULTURAL AWARENESS

In South Australia a project officer will be based at the Migrant Resource Centre to undertake Reciprocity in Education - a community based model for cultural

awareness in mental health. This initiative will develop and trial a model of educational interaction between members of strategically selected culturally and linguistically diverse communities and health care providers. It will focus on cultural awareness in mental health at a community level, concentrating on depression. After reviewing the literature on transcultural training and education in mental health, the project will develop training and education programs and packages for community educators, consumers and carers. The project officer will also be responsible for conducting multi-lingual forums and consultations with collaborating communities.

Dr Nicholas Procter
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Email: nicholas.procter@dhs.sa.gov.au

WESTERN AUSTRALIA

PROMOTING CULTURAL AWARENESS IN THE MANAGEMENT OF MENTAL ILLNESS: A RESOURCE KIT FOR PRACTITIONERS

In Western Australia the "Promoting cultural awareness in the management of mental illness: a resource kit for practitioners project" will develop and evaluate an information kit to be used by mental health practitioners to promote a culture specific awareness in the management of mental illness in culturally and linguistically diverse communities. The kit will provide practitioners with general guidance in how to manage clients with mental illness in a more culturally aware manner. The kit will also assist practitioners in all aspects of management from assessment, diagnosis and formulating treatment plans. The resource kit will guide practitioners in obtaining from their clients an understanding of the presenting problem using culturally sensitive approaches.

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ACT

MENTAL HEALTH SERVICE PROVIDER EDUCATION AND TRAINING PROGRAM

A community and mental health service provider education and training program will also be undertaken in the Australian Capital Territory. This initiative will raise awareness amongst people from culturally and linguistically diverse communities of the issues surrounding mental illness including prevention and early intervention and assisting in the reduction in the stigma associated with mental illness.

A project officer will be appointed to undertake education and support programs targeted at culturally and linguistically diverse communities in the ACT. The project will utilise ethnic media (including local newsletters and publications) to promote a clearer understanding of the mental health services available. The project officer will also develop and implement a training program for GPs, mental health professionals and mental health service providers on effective services for the target communities.

Judith Davis Lee
ACT Dept of Health & Community Care
phone: (02) 6207 5994

QUEENSLAND

INDICATED PREVENTION SHARED CARE PROGRAM WITH PEOPLE OF NESB SHOWING EARLY SIGNS & SYMPTOMS OF MENTAL DISORDER;

MODIFICATION OF "FRIENDS" – STRATEGIES FOR PREVENTION OF ANXIETY IN YOUNG PEOPLE FROM CALD AND DEVELOPMENT OF AN ANXIETY PREVENTION PROGRAM

Two projects have been funded in Queensland. The first is being managed by the Brisbane Inner South Division of General Practitioners (GPs): Indicated prevention shared care program with people of NESB exhibiting the early signs and symptoms of mental disorder living in inner south Brisbane – a demonstration project. The second by Griffith University: Modification of "Friends" – strategies for the prevention of anxiety in children and young people from culturally and linguistically diverse backgrounds and development of an anxiety prevention program for new arrivals.

The indicated prevention program has been designed to establish a shared care program for people from culturally and linguistically diverse communities displaying the early signs and symptoms of a mental disorder. The project aims to recruit, train and resource General Practitioners in inner south Brisbane to work in partnership with mental health workers and services supporting people of diverse backgrounds. A shared care resource kit will be developed and trialed by the GP's involved with the project. A final

review process will be conducted to evaluate the effectiveness and cost effectiveness of the shared care model.

At Griffith University work will be undertaken to modify the existing, well-validated FRIENDS anxiety prevention program for children and young people into a more culturally appropriate universal program that meets the diverse needs of culturally diverse participants including people from non-English speaking backgrounds, indigenous and Anglo Australians. This universal program is intended for use with culturally diverse groups in the classroom. The second component of the program is the development of a targeted anxiety prevention program for children and young people from countries where English is not the first language who have recently arrived in Australia. This tailored program is intended for delivery in special schools, ESL classrooms and through ethnic community services and groups.

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VICTORIA

TRANSCULTURAL PSYCHIATRY FOR CLINICIANS:

CD-ROM & INTERNET TRAINING PROGRAM FOR MENTAL HEALTH PROFESSIONALS

In Victoria, the Victorian Transcultural Psychiatry Unit will undertake the project Transcultural Psychiatry for Clinicians: a CD-ROM and Internet based training program for mental health professionals. This initiative will develop a flexible training program (equivalent to a standard semester long subject) to introduce health professionals to key issues in ethnicity, culture, migration, cultural aspects of mental illness, cross-cultural assessment, diagnosis and treatment. The training package will be delivered using a combination of the Internet and a CD-ROM program and will be designed to develop awareness of the impact of culture in mental health care and services. The training package will target mental health professionals employed as practitioners in mental health services who wish to take the course as a stand alone professional development program. Upon completion, the materials will be available for use by any other tertiary institution who may wish to use content in their own training programs.

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SUICIDE INFORMATION on the WEB

YOUTH SUICIDE

AUSEINET

www.AusEinet.flinders.edu.au

Australian Early Intervention Network for Mental Health in Young People Funded under the National Mental Health Strategy and the National Youth Suicide Prevention Strategy.

HERE FOR LIFE

www.hereforlife.org.au

Here for Life is a not-for-profit public benevolent institution focusing on education, awareness and research aimed at the prevention of youth suicide.

KIDS HELP LINE

www.kidshelp.com.au

A national phone counselling service, also includes counselling statistics by sex and subject, and information sheets on topics such as domestic violence, homelessness, bullying, suicide etc.

LIFELINE: MAKE THE CONNECTION

www.lifeline.org.au/connect/

The web site provides information about what to do after a suicide - finding support - making sense of it all - putting the pieces together; and linking with supports and services on the Net and in the community.

MAKE A NOISE

www.makeanoise.ysp.org.au

The official homepage of Youth Suicide Prevention in the Greater Murray area New South Wales, a project for young people, run by young people.

RESEARCH

AUSTRALIAN INSTITUTE OF SUICIDE RESEARCH AND PREVENTION, GRIFFITH UNIVERSITY

www.gu.edu.au/school/aisrap

The Institute promotes, conducts, and supports research on suicide prevention in Australia.

GOVERNMENT SITES

NATIONAL YOUTH SUICIDE PREVENTION STRATEGY

www.health.gov.au/hsdd/mentalhe/nysps/index.htm

VICTORIAN GOVERNMENT YOUTH SUICIDE PREVENTION TASK FORCE

<http://hna.ffh.vic.gov.au/info/sptf/>

WESTERN AUSTRALIAN YOUTH SUICIDE PREVENTION INFORMATION KIT

www.youthaffairs.gov.au/programs/suicide

YOUTH SUICIDE PREVENTION KIT

www.infoxchange.net.au.dhs.youth.suicide/

INTERNATIONAL SITES

AMERICAN FOUNDATION FOR SUICIDE PREVENTION

www.afsp.org

The Foundation is dedicated to advancing the knowledge of suicide and the ability to prevent it.

CANADIAN SUICIDE INFORMATION AND EDUCATION CENTRE

www.siec.ca

Established in 1982 the Centre is the largest English language suicide information resource centre and library in the world. Resources include: an extensive CD-ROM; document delivery; information kits; pamphlets; publications; suicide helpcards; videos.

SUICIDE PREVENTION INFORMATION NEW ZEALAND (SPINZ)

www.spinz.org.nz

SPINZ is a joint project with the Centre for Youth Health, South Auckland Health and The Mental Health Foundation of New Zealand.

THE SAMARITANS

www.samaritans.org.uk

A national UK organisation which exists to provide confidential emotional support to any person who is suicidal or despairing; and to increase public awareness of issues around suicide and depression.

The Children Bereaved by Suicide Project

Kerrie Noonan
Grief Counsellor, Liverpool Community Centre

The children bereaved by suicide project began in South Western Sydney just over 2 years ago with the aim of increasing services and resources for children bereaved by suicide in their families. The project focused specifically on children aged 12 and under, as this group was identified as among the most disenfranchised of those left affected by suicide.

Young children, particularly those under the age of 10 are less likely than older children to be told about the cause of death. This often contributes to children being unable to participate in important mourning rituals such as the viewing or funeral and more generally can impact on how a family grieves and supports one another. This article will discuss some of the issues faced by children bereaved by suicide and provide a brief summary of some of the findings of the project.

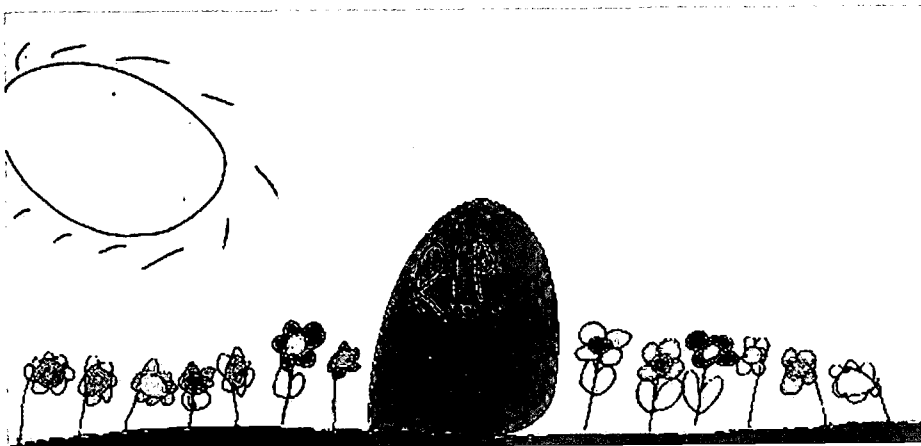
The impact of suicide is far reaching and while individuals bereaved by suicide experience a grieving process in common with other bereaved people, it is widely acknowledged that grief from suicide is particularly stressful. It appears that the combination of sudden, traumatic death and the knowledge that the death was a self inflicted and a self chosen act contribute to the intensity of grief reactions (Cleiren and Diekstra, 1995). Researchers have delineated a number of factors found to contribute to the risk of complicated grief reactions in suicide survivors. These include intense emotional reactions such as guilt, feelings of responsibility, shame, social rejection and alienation and blame (Pfeffer et al., 1997; Silverman et al., 1994; Demi and Howell, 1991); stigma, and decreased social support (Raphael, 1984; Ness and Pfeffer, 1990; Demi and Howell, 1991; Allen et al., 1993; Pfeffer, et al., 1997); and the finding that suicide often occurs within systems already experiencing stress and these multiple stressors can prolong

or complicate grief (Rudestam, 1992).

It is difficult to estimate how many children are affected by suicide in Australia each year. Some writers estimate that 6-10 immediate families members and friends are left bereaved following a suicide. What we do know however is that the highest number of suicides (approx 44 percent) occur in the 25-44 year age group, which is the age group most likely to have young families. This would suggest a high number of children affected by parental suicide alone. Children bereaved by suicide therefore, face a number of challenges impacting on their grief process - they are less likely to be told about the cause of death, less likely to be included in mourning rituals, and caregivers commonly have concerns that knowledge about suicide will increase a child's emotional distress and have long-term ramifications on emotional development. Furthermore children, are experiencing grief within the cognitive and emotional constraints of childhood. This developmental context can influence not only the child's concept of death but also the way they mourn and the type of grief support they receive. The following summarises the psychosocial factors associated with child survivors of suicide. These include:

Depressive symptoms found to be present in up to 30% of suicide-bereaved children (Cerel et al., 1999; Pfeffer et al., 1997)

A high degree of externalising behaviour and social



The Children Bereaved by Suicide Project does not focus specifically on children from culturally and linguistically diverse backgrounds. If anyone is working in this field and would like to write on their work, please contact the editor of Synergy (contact details on page 44).

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WORLD HEALTH ORGANISATION

MENTAL DISORDERS CAN BEGIN IN TEENAGE YEARS AND GO UNTREATED FOR LIFE

Press Release 4 May 2000

Mental disorders are becoming more common, often beginning in the teenage years and afflicting many sufferers for the rest of their lives, according to an international psychiatric study. Almost half of those who are ill don't seek help, most are not treated at all, and often the treatment is inadequate – even though effective therapies exist, the research shows.

The findings are published in the latest issue of The Bulletin of the World Health Organization. The issue, dated April 2000, is devoted to mental health, and in an accompanying editorial, WHO's Director-General Dr Gro Harlem Brundtland says: "Mental illness suddenly bulks very large indeed. All predictions are that the future will bring a dramatic increase in mental problems. It is a crisis of the 21st century."

The WHO International Consortium in Psychiatric Epidemiology examined data from 30 000 people in seven countries – Brazil, Canada, Germany, Mexico, the Netherlands, Turkey and the United States – Researchers found that 48% of those studied in the US experienced at least one disorder in their lifetime, compared to 40% in the Netherlands, 38% in Germany, 37% in Canada, 36% in Brazil, 20% in Mexico and 12% in Turkey.

Overall, the median age of onset for anxiety disorders was just 15 years, 21 years for substance use disorders and 26 years for mood disorders. Delays in seeking treatment were especially pervasive among people with early onset of symptoms. All three classes of illness were most common in disadvantaged sectors of society, and linked particularly to people with low income and below-average education, or who were unemployed or unmarried.

Anxiety disorders were most likely of the three to become chronic, and more common in women than men, as were mood disorders. Substance use disorders were more common among men.

"The proportion of the life course during which people with mental disorders are actively in [a mental disorder] episode is substantial", the researchers report.

"This substantial burden is especially important in the light of the fact that mental disorders often have a devastating effect on role-functioning and quality of life.

"They also have powerful adverse effects on critical life course transitions such as educational attainment, teen childbearing, marital instability and violence."

The researchers add: "It is discouraging to find that the vast majority of recent cases, even those who report substantial impairment, are not in treatment". Whereas it is not yet known whether early treatment could prevent the adverse life course effects of mental disorders that have early onset, the researchers say it is "critically important" that early "outreach treatment" efforts are refined, implemented and evaluated.

In her editorial, Dr Brundtland says there are several reasons why effective treatment for disorders such as depression is not provided. "The main reasons are the low priority given to mental health, the traditional centralization of mental health services in large, ineffective and often downright harmful psychiatric institutions, and poor application of cost-effective mental health strategies.

"There is also the stigma of mental illness, which inhibits sufferers from seeking treatment, and which may even limit the willingness of mental health care providers to intervene.

"Mental health depends on some measure of social justice, and mental illness, given its scale, must be treated effectively at primary level where possible."

Dr Brundtland has identified mental health as one of WHO's main priority areas. The World Health Report, published annually by the Organization, will be devoted to mental health in its 2001 issue.

Whispers of Wailing and Wisdom Behind the Walls of Silence

Vicki Katsifis

Consumer Project Officer, NSW Transcultural Mental Health Centre

Consumer presentations are important and have a vital place in conferences. They give a human face to the dialogue and continually keep us humble, reminding us that we do not have all the answers. Health professionals, consumers and carers need to have inquiring minds on methods of healing as their healing is so dependent on the individual person, their circumstances, past background and personal view on life.

If we do not hear these human stories we risk teaching people that there is only one or two ways to help, when a diversity of ways is needed. Consideration of the consumer and carer voice should always form a part of our understanding.

There is not much time in this conference for me to talk about the effect of suicide from a consumer perspective but there will never be enough time. Suicide is a complex experience that is unique and individual according to one's social and cultural milieu.

Wherever I go I can hear the whispers and echo of wailing and wisdom from shadows darting in and around my own psyche. It is like living in a house whose rooms you have never fully explored, places you have never seen. Sometimes strange sounds come from those distant quarters and you wonder if somebody else is living here with you maybe you pass each other in dark corridors each thinking the other is merely a shadow. We were never allowed to talk about suicide as a Greek family, we were alienated from that part of our experience and suffering as carers and as consumers. Fear that talking about it would make it real, the end result producing an adult who will perhaps never want to stop talking about it.

In the consumer movement and through my own personal friendships I have had ample time to come to terms with some of the suicides that have confronted me through the years. Through support groups, peer counselling and personal journal writing I have come to an understanding and acceptance of the reasons why someone would leave too soon.



Vicki Katsifis

Continued Overleaf

Synergy Winter 2000

When it comes to suicide prevention in the context of my own family the situation is vastly different. The only metaphor I struggle to come up with is this forced need to whisper behind closed doors, to be screaming inside that I am so depressed at this current time that I want to end my life. Suicide is not something to be discussed or talked about. If I say that I feel unwell or suicidal my family will look towards things such as my diet as a possible reason. Or even encourage me to whisper "Sh. don't be silly you are young and have everything to live for"

I have been brought up with Oprah Winfrey, self help books, a model of peer counselling and recovery but in my own home it is something not to talk about. So we whisper. And then we wail and hope somebody will hear. This is often the predicament of two cultures colliding within the same household. And also of two personalities colliding. I am a deeply expressive person that believes in thrashing ideas out whereas my culture finds it unbecoming to talk of weakness or illness. And hence the whispers.

What of the wisdom. What can we learn from ethnic communities to support suicide prevention. Ethnic communities believe in family. Social support is a significant factor in proving to someone that they will be

missed and that they are loved and needed.

A useful scenario to remember is when my brother broke down crying and told me how he feels hearing me say I want to die. I am his only sister. I am the one who remembers our early high school pranks and all the fun times we had growing up. Who will he have if I am gone. I am loved. *I am significant in his life.* Families allow us to remember this fact even when we are ensconced in depression and our own sadness. Just one person reminding us makes us temporarily reevaluate the decision to die. Depending on whether we are serious or whether we are crying out for help people need to feel needed and loved and respected for who they are as an individual. Friends and workmates can provide this, but if you live with people who are strong on providing this you are halfway there. I remember seeing a friend of mine two months before he committed suicide. He was alone, hungry and living in a derelict flat. I was surrounded by family and friends and had just returned from a holiday. I had work that I was proud of and this helps prevent suicide-feeling useful, needed, wanted and valued for your accomplishments.

Religion is a protective factor. If one is brought up with a strong religious background from a very young age it

provides a framework that can provide resilience in later life. My late father taught me that things happened for a good reason and sincere prayer has a place in life.

My mother's handling of her mental illness continually astounds me. She doesn't want to talk about it much. Even though this is seen as denial by people brought up in Australia, to her it is part of leaving the past where it belongs and soldiering on into the future. She soldiers on.

Being involved in peer support and counselling I believe that people need to be validated and heard. People need the right information in order to help their family members. Support and/or information groups are important in providing this information in a language specific and culturally appropriate manner. For the wailing will go on unanswered and the wisdom will have no place to be shared and utilised to prevent the preciousness of lives. So the wailing goes on but in a more concise and productive way. We now wail for attention to be drawn to support groups, language specific forums, creative outlets for NESB consumers and carers to translate their pain into a format that is acceptable to them and the community they live in. □



Suicide in Immigrants Born in Non-English Speaking Countries

The Latest Research

Bob McDonald, Zachary Steel

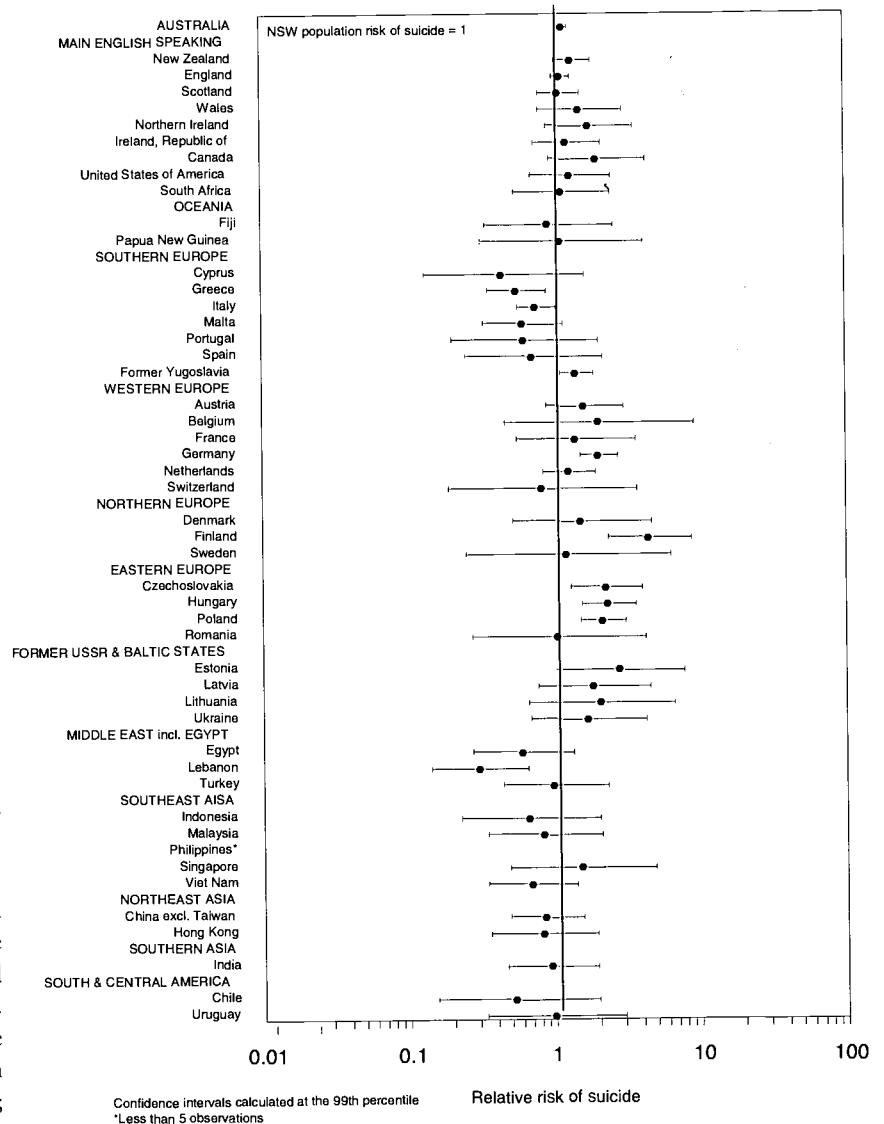
An extensive literature on the suicide of immigrants in Australia has developed, particularly in Western Australia and Queensland (Burvill, Armstrong & Carlson, 1983; Burvill, McCall, Stenhouse & Reid, 1973; Burvill, McCall, Stenhouse & Woodings, 1982; Burvill, Woodings, Stenhouse & McCall, 1982; Edwards & Whitlock, 1968; Whitlock, 1971) and more recently in NSW (McDonald & Steel, 1997).

One of the most consistent findings emerging from this research is the great diversity in the rates of suicide by immigrants from different countries of birth (Burvill et al., 1983; Burvill et al., 1973; Burvill et al., 1982; Hassan, 1995; McDonald & Steel, 1997; Whitlock, 1971).

For example McDonald & Steel (1997) found that the standardised mortality rates of suicide were highest for immigrants from countries in Western, Northern and Eastern Europe, and the former USSR and the Baltic States, while the lowest rates were for immigrants from Southern Europe, Middle East/Egypt and Asia.

Aggregating suicide mortality data over the 23 year period between 1970 to 1992, McDonald & Steel (1997) reported that for females significantly higher relative risks of suicide (compared to the NSW average) were found for those born in Hungary (265% higher than the NSW state average), Austria (181%), Czechoslovakia (180%), Poland (121%) and Germany (72%). With males, significantly higher risk of suicide was found for those from Finland (283%), Hungary (100%), Czechoslovakia (93%) and Germany (73%). Significantly lower risks of suicide were found for females from Greece (67% lower than the state average). The results obtained by McDonald & Steel (1997) are presented in Figures 1a,b. These findings are very similar to those that have been reported elsewhere for immigrants in Australia (Burvill et al., 1982; Whitlock, 1971; Young, 1986).

Figure 1a Relative Risk of Suicide by Male NSW Residents by Country of Birth (1970 to 1992)



A second finding regularly reported is that the rates

Continued on page 38

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Australian Transcultural
Mental Health Network
2nd National Conference

3rd Australian
Multicultural Health
Conference

NSW Transcultural
Mental Health Centre
6th Conference



Diversity in Health

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28-30 May 2001

Sydney Convention and Exhibition Centre
Darling Harbour, Sydney

Further information/expressions of interest, call 61 2 9518 9580 or email diversity@pharmaevents.com.au

Feeding Transcultural Psychiatry Into The Mainstream

Culture and mental health was the core theme of the 35th Congress of the Royal Australian and New Zealand College of Psychiatrists which was held in Adelaide between the 27th and the 30th April this year. The title of the Congress was "Looking Outward: Culture, Creativity and Psychiatry." It involved a deep exploration of the relationship between psychiatric practice and the cultural context in which this practice is situated.

There was a focus on transcultural psychiatry as well as on mental health issues pertaining to the indigenous communities of Australia and New Zealand. In addition we attracted a strong consumer input, which included a plenary session and a number of concurrent sessions that were run by consumers and carers for psychiatrists.

The indigenous stream ran throughout the entire four days of the meeting, with a wide range of papers, workshops, and plenary sessions. Two of the most remarkable of these were the showing of a film, "Cry from the Heart," with a discussion led by our keynote speaker, Lola McNaughton (who plays a main role in this documentary), and a seminar given by Rupert Peters and Andy Tjilari, two Ngankaris (traditional healers) who described the healing work they do in the centre of Australia.

The transcultural stream also ran from beginning to end, and presented a rich array of cultural issues to mainstream psychiatrists. The very first plenary address, presented by Professor Bruce Singh, "Australia in the Global Village," highlighted the importance of engaging with mental health professionals in the Asia/Pacific region. Professor Laurence Kirmayer presented his work among First Nation and Inuit Peoples in Canada, and he was involved in a workshop which was very well attended (standing room only) that raised issues to do with somatization and culture. Professor Leslie Swartz, from Cape Town, brought a South African perspective to the meeting, with his discussion on culture and social change, and its impact on mental health, and Professor Rosalba Terranova presented the Italian experience in her talk on cultural sensitivity and transcultural practice in Italy.

The work of the Commonwealth Department of Health and Aged Care and the ATMHN was articulated with great clarity and finesse by Conrad Gershevitch, and a New Zealand perspective was provided by Wayne de Beer. From the Migrant Health Service in Adelaide, Rosie Bonnin played a key organizing role in the transcultural stream, and Tindaro Fallo presented some of his collaborative work with the Italian psychoanalyst, Mario Pigazzinin, on totem and sacrifice.

A workshop that generated great deal of interest was that organized by Frank Varghese on ethnic identity and the self, with a special focus on the implications of ethnic identity for psychotherapy.

The workshop brought together a range of contributions, including that of Lifeng Chen, from Queensland, and Deji Ayonrinde from the Maudsley Hospital, London, who spoke on ethnic and cultural dimensions in therapeutic transactions.



Professor Rob Barrett
Convenor

It was gratifying to observe undergraduate students and trainee psychiatrists becoming involved in transcultural issues. Nicole Agzarian, a fourth year medical student from the University of Adelaide presented her work on the effects of relocation and family functioning on Iranian refugee families. And in the final plenary session, Harry Minas outlined a vision for the future of socio-cultural aspects of training for psychiatrists.

The ATMHN ran a very smart and informative booth, which occupied a prominent position in the Congress Hall. It was manned (womanned ?) by the stalwarts, Meg Griffith and Sandee Baldwin. The importance of this booth is that it attracted a large amount of interest from Australian, New Zealand and international delegates, on the activities of the ATMHN, and has had a tangible effect in expanding our network of interested clinicians.

The final touch of the Congress was the dinner-dance, for which we hired Finelines, a consumer band from Adelaide's western suburbs. It was a wonderful sight indeed, to see hundreds of psychiatrists dancing to the tune of the consumers.

Rob Barrett
Convenor

Cultural psychiatry & medical anthropology: an introduction and reader

Edited by Roland Littlewood and Simon Dein 616.8921
This publication is designed to explore an expanding new field of interdisciplinary study. Each of the extracts has been selected to illustrate issues of contemporary interest – these include medicine, and magic, sexuality, death, psychosis, anxiety, symbols mental disease and mental disease.

Carer profile: the value of carer assessment in supporting carer/family relationships

1999 362.04250994 21 HUG
Sydney, Carers Association of New South Wales.
While this project addresses the needs of carers in NSW, it provides a model for carer assessment in other Australian states.

Healing Communities in conflict: international assistance in complex emergencies

Maynard, Kimberley. 362.8 MAY
The author has worked as an on-site consultant in many areas such as Rwanda, Bosnia-Herzegovina and Kosovo. He outlines how the international community can be more effective in the war-torn, disaster scarred regions of the world-and ensure that people in conflict can rebuild their communities after the fighting stops.

Health and human rights

Mann, J et al 174.21 HEA
This book is written for health workers, human rights workers and others interested in protecting and promoting health and human rights.

Intercultural Therapy

Kareem, J and Roland Littlewood (Eds)
There are many problems in working psychotherapeutically across cultures, with numerous examples of failure to understand cultural issues. This book explains the theories and techniques on intercultural therapy, and includes different views on intercultural therapy given by a group of specialists who have pioneered this developing area.

Living in a new country

Rice, Pranee Liamputtong 362.1089 LIV
Not all immigrants are refugees. Some choose to leave the country of their birth to go somewhere that they believe will give them a better life. The editor has gathered researchers whose work is invaluable in demonstrating what happens to the health of people who move to live in another country. From babies born into migrant families to elderly parents who follow their children.

Bodies under siege: self-mutilation and body modification in culture and psychiatry

Favazza, A. 616.8582 FAV
The author offers new information on the diagnosis and treatment of self-mutilation, on the link between self-mutilation and eating disorders. He draws upon case studies from clinical psychiatry and cultural anthropology to broaden our understanding of self-mutilation and body modification and to explore their surprising connections to the elemental experiences of healing, religion, and social balance.

Guidelines for culturally sensitive mental health practice

Steven Klimidis, Sermin Baycan and Janet Punch. 2000
The purpose of these guidelines is to provide clinical staff who are working in mental health settings information on the policy and legislative context for culturally sensitive clinical practice. Although set in regional Victoria, the information is useful for any mental health professional who wishes to obtain a broader model for clinical practice.

Al-Junun : Mental illness in the Islamic world

Ihsan Al-Issa (Ed) 2000 362.2 ALJ
This is essential reading for those who are involved in the multicultural world of the global village. It provides medical professionals with a better understanding of their clients who represent the Islamic culture. Although it shares many ideas with Western forensic psychiatry there are unique forces that bring diversity under the banner of Islamic unifying beliefs.

ATMHN WEBSITE

The most important addition to the website is the ATMHN online Library Catalogue, where you can search the library catalogue using title, author or keyword commands to see if a book is currently on loan or on the shelf, plus many more features. Please click the Search button to access the online library catalogue. This button is now also located on the homepage for easy access. The Search button can also be used to quickly locate any page on the entire ATMHN Site.

The What's New section includes up and coming events around Australia, if you would like to add a related event, please email the coordinator at: l.stokes@medicine.unimelb.edu.au

www.atmhn.unimelb.edu.au

WORKING TOWARDS CULTURALLY RESPONSIVE HEALTH SERVICES

a summary of the PROMOTING PARTNERSHIPS IN NESB WOMENS' MENTAL HEALTH PROJECT funded by the National Women's Health Program

BOOK REVIEW by Jenny Luntz

The project was a collaborative partnership between two mainstream organisations, Women's Health Statewide (WHS) and the Eastern Community Health Centre (ECMHS). They both shared the vision of improving access, equity, communication, responsive, effectiveness, efficiency and accountability towards their culturally and linguistically diverse (CALD) female clients.

The two main players in the partnership were a project officer specifically appointed to Women's Health Statewide (WHS) for twelve months; and the transcultural development worker (TDW) already employed at the Eastern Community Health Centre (ECMHS). The task of the project officer was to 'assist each organisation develop and sustain best practice...address the mental health needs of women from diverse linguistic and cultural backgrounds' (p 11).

The TDW's role involved: providing clinical services to members of one of the key ethnic communities; consultation to other clinicians with respect to their cross-cultural clients; as well as the community development task of change agent where the aim was 'to influence organisational change, through cultural development of services in the region' (p 12). This worker was not confined to working only with women.

The partnership took the form of regular peer support meetings between the project officer and the TDW where the main agenda was to assist in the embedding of cultural diversity as a more central feature of the service.

An important initiative was the inclusion of relevant ethno-specific agencies and consumer representatives on a steering committee where their role involved representing CALD consumers experiencing mental health difficulties. The feedback gained from this initiative influenced policy and practice within the ECMHS as it aided management to develop structures to ensure accountability with respect to access and equity matters. By the project's end the TDW attended management team meetings regularly and contributed to discussion and decision making at both a central and a regional level. Her role as service developer was endorsed.

The change process made use of existing Federal, State and Local Government policies and standards (eg National Mental Health Policy [1992]). On these were based carefully thought through strategic planning which focused on the changes required both inside and outside the organisation. In developing these strategic plans the participants projected themselves into the future and tried to ascertain the impact such changes would have on future organisational and worker behaviour. A part of this involved contemplating whether such

behaviour would impact positively on client access. They also sought to answer some fundamental questions eg Why does the organisation want to improve access and equity? How adequate are current practices? What needs to be addressed first? The booklet stresses the need to be realistic in setting goals; establishing timelines; providing mechanisms for assessing the extent and rate of the change process.

They point to the fundamental role management's commitment makes in bringing about the needed changes; and that such commitment includes:

- the allocation of adequate funds and appropriate resources;
- opening channels of communication;
- acknowledging to staff the difficulties inherent in bringing about change and supporting them during the change process.

It is not sufficient to make changes; they also need to be integrated so they become part of the organisation's culture. Ensuring that this happens is part of the planning as well as part of the implementation process. Some of the changes made by the project were the employment of bilingual workers and providing them with the mandate to assist in increasing cultural competencies with the staff at large. They were also provided with the adequate support required to play this role.

Developing successful partnerships between agencies is in itself a difficult task. When such partnerships lead to substantial changes in agency structures and practices, it is even more remarkable.

As the participants were involved in this process they also managed to keep one eye on the change process itself. By doing so they are now able to share with others what aspects of the process worked and why. This is possibly the most difficult challenge of all. They are to be commended for the way they did this and for their generosity in sharing it through writing this booklet.

The authors see the booklet's value for managers and workers responsible for implementing organisational change to benefit people who are culturally and linguistically diverse. The lessons are much wider than this. They are germane to all organisational change and the involvement of inter-agency partnerships in order to bring about such change.

The full report can be obtained from Women's Health Statewide, 64 Pennington Terrace North Adelaide 5006 phone 08 8267-5366, fax 08 8267-5597 email whs@peg.apc.org

FIRST FORUM OF THE SA TRANSCULTURAL MENTAL HEALTH NETWORK

PROMOTING MULTICULTURAL HEALTH AND WELLBEING

Looking to the future for communities,
consumers, carers and service providers

The forum aims to bring together multicultural community groups, carers, and service providers to look at the issues surrounding the wellbeing of multicultural Australia. The forum will address a range of themes including rural and remote issues.

17-18 NOVEMBER 2000

Adelaide Congress Center
ADELAIDE

ABSTRACTS

Presentations are welcome in a range of formats: including papers, workshops, posters, performances and artwork.

When submitting you abstracts please send one page only describing your topic and how you would like to participate.

Please include your address, phone, fax and email details.

Deadline for abstracts is October 13, 2000.

ENQUIRIES

All enquiries for presentations and registrations please contact:

NESBWEB Forum Convenors
21 Market St
Adelaide 5000

Tel: 08 8200 3900
Fax: 08 8200 3949

Reciprocity in Education Project

Dr Nicholas Procter will undertake the role of managing the Reciprocity in Education Project from May this year. Dr Procter is a Mental Health Nurse with postgraduate qualifications in Adult and Community Education and Sociology. He holds academic appointments at Adelaide University and the University of South Australia and has undertaken a range of projects in community mental health and adult education.

The Reciprocity in Education Project is a 12-month pilot activity aimed at developing a model of interactive learning between three NESB communities and mental health care providers. The model will be based on principals of reciprocity, social capital and capacity building and hinge upon the direct involvement of community educators. The educational interaction is planned to focus on cultural awareness in mental health as related to sadness and depression (broadly defined). The ideas underpinning this project are based upon the fundamental belief that an absence of local services, or lack of culturally appropriate or sensitive services, can and will prevent access of individuals groups to effective treatment for mental health problems across the life span. An expert advisory committee who will provide practical help, support and advice to help meet its aims and objectives will support the project. To this end, it is expected that this project will add to existing forms of mental health literacy, networking and information exchange between mental health service providers and ethnic communities. That is, a model of educational interaction that leads

to increased awareness, respect and understanding of reference points, beliefs and ways of knowing and responding to mental health issues and problems.

From the very beginning this project will at all times be deliberately and convincingly practical in the way that it progresses so that upon completion it will be able to tell the story of what happened, how it happened, what worked well and what did not work well. While rigour and academic influences are seen to be important, the story behind scenes involving the planning, development and evaluation of the interactive model between NESB communities and mental health providers will be both accessible and reader-friendly to a wide and varied audience. It is hoped that mental health consumers, carers and professionals will gain understanding of what this project did in order to make meaningful, strategic and mutually beneficial connections with ethnic communities. While this information is important in its own right, it is hoped that it will help to strengthen existing partnerships between communities of diverse cultural and linguistic backgrounds and mental health services.

A preliminary consultation and planning process has begun in order to gain understanding of potential groups who might be involved in the project.

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Preliminary Findings of the NESB Youth Mental Health Needs Assessment Project

In the sunny autumn months QTMHC has been busy attending parliamentary launches. Additionally, QTMHC continues to expand and strengthen: prevention and promotion activity; educational and professional development programs and service innovations that enhance the quality and accessibility of mental health services available to people from culturally and linguistically diverse backgrounds (CALD).

On the 4th April, the Honourable Wendy Edmond (QLD Health Minister) launched the 'Preliminary Findings of the NESB Youth Mental Health Needs Assessment Project' for National Youth Week. The preliminary findings are considered a significant milestone in response to providing essential qualitative data concerning the mental health needs of NESB young people. The project is coordinated in partnership by QTMHC and the Youth Affairs Network of Queensland (YANQ) and has been

operational since December 1998. However, there have been variable opportunities and challenges in terms of building the Queensland based study into a project of national significance by developing collaborative partnerships with South Australia and West Australia.

The opportunities are highly visible when reviewing the preliminary findings. These include: partnerships developed across Australia involving QTMHC, YANQ, Youth Affairs Council of South Australia, Migrant Health Service (SA), Youth Affairs Council of Western Australia and the Transcultural Psychiatric Unit (WA); recruitment and training of 19 bilingual interviewers across 3 States; completion of in-depth interviews with 198 participants; and a preliminary analysis of young people's interviews.

Conversely, the challenges have involved considerable funding restraints and required the research stakeholders to make very important management decisions. For example, the initial project analysis of the Queensland based study was intended to be

more general but when the project expanded nationally the quality, depth and volume of data collected was in retrospect underestimated. Acting upon expert advice about the research and ethical importance of reporting on such an extensive database, the urgent need was established to re-orientate time and costings to complete a high quality preliminary analysis and to publicly launch the results in National Youth Week.

Agreement was also made to lobby for further funds to complete the in-depth qualitative analysis, conduct a post-analysis validation workshop with bilingual research assistants in Qld, SA and WA and to produce fact sheets for participating ethnic communities and the final research report. However, while ongoing funds are being secured, the preliminary findings offer some valuable insights about NESB young people who self identify as experiencing depression, anxiety and/or extreme stress.

Quotations from the Preliminary Findings of the NESB Youth Mental Health Needs Assessment Project are presented below:

WHY IS THIS PROJECT SO IMPORTANT?

Young people of NESB have many things in common with other young people in the community at large. Issues such as unemployment, poverty, pressures at school and at home, and alcohol/drug abuse may be experienced by any young person. However, as a group, young NESB people also experience pressures, problems and difficulties that add to the complexity of the problems they may face. For instance, young people of NESB may experience feelings of not belonging, unpopularity, loss and grief (especially for refugees) and homesickness. They may also experience language barriers, racism and the pressures of cultural adaptation in a foreign land. These factors constitute additional stressors that can lead to mental health problems and, in cases where a predisposition to psychiatric disorders is present, to serious mental illness.

Of particular concern is the relationship between poor mental health and suicide among young NESB people. There are a large

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number of stressors and triggers which may impact on a young person's decision to attempt or commit suicide, however there has been little research which describes the individual or collective cultural needs of young NESB people experiencing mental health problems. Without this research it is difficult to develop appropriate suicide prevention strategies which acknowledge the diverse needs of NESB young people

PARTICIPATING COMMUNITIES

In order to acknowledge the diversity of NESB experience in Australia it was necessary to include a variety of NESB communities. The following communities participated in the study: Arabic speaking Communities, Cambodian, Chinese, Colombian, El Salvadorian, Former Yugoslavian, Greek, Lebanese, Somalia and Sudanese.

The communities were selected in order to ensure that the experiences of recently arrived migrants and refugees as well as more established communities were adequately considered. Moreover it was equally important to ensure that the diversity of cultural experiences emerging from Africa, Asia, Europe and South America were represented in the study.

Total number of interviews conducted by ethnic communities and total gender (Queensland, Western Australia and South Australia)

| <u>Communities</u> | <u>No</u> |
|--------------------|-----------|
| Anglo-Indian | 1 |
| Arabic Speaking | 14 |
| Australian | 1 |
| Cambodian | 10 |
| Chinese | 38 |
| Colombian | 1 |
| El Salvador | 7 |
| Ethiopian | 2 |
| Former Yugoslavia | 60 |
| Greek | 14 |
| Lebanese | 2 |
| Somali | 26 |
| Spanish | 4 |
| Sudanese | 18 |
| Totals | 198 |
| Male | Female |
| 89 | 109 |

The following is a breakdown of the four categories of interviews carried out:

- 118 Young People
- 41 Care Givers
- 15 Mental Health Service Providers
- 23 Other Service Providers

(Source: Info Sheet 1, The Social and Emotional Wellbeing of Young People, YANQ and QTMHC, 2000)

PRELIMINARY ANALYSIS

The overriding theme from the questions related to cultural practices, was one of cultural isolation. Participants commonly talked about the difficulty of practising their own culture due to the importance in those practices of social involvement with large extended families and the community. As these were not available to them in Australia, even when they did carry out cultural activities they were reported as not being the same without the larger group.

It is not difficult to see how this loss of cultural belonging can be highly stressful and equally importantly deprive the individuals of their usual source of support. This is reflected in the responses to later questions where participants were asked to make suggestions about what could be done to assist. There was a range of suggestions that could be interpreted as having a common theme of meeting a need for participation in ethnic communities.

MAJOR THEMES

The following are major themes that have been identified so far from the analysis:

1. Strategies identified by the participants as useful in coping with their problems
2. Strategies identified by the participants as not useful in coping with their problems
3. Participants for recommendations for:
 - a) Youth Support
 - b) Broad Policy
 - c) Education
 - d) Employment

For further information on the Preliminary Findings of the NESB Youth Mental Health Health Needs Assessment Project contact:

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Promotion and Prevention
Coordinator QTMHC
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or

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Preliminary Findings of the NESB Youth Mental Health Needs Assessment Project continued

(Source: Info Sheet 2, The Social and Emotional Wellbeing of Young People, YANQ and QTMHC, 2000)

USEFUL COPING STRATEGIES INCLUDE:

1. Entertainment/Distracton (76% n90) eg music, movies, nightclubs etc.
2. Socialising (52% n63) – this was seen as a way to avoid brooding on the problem and usually referred to friends, belonging and therefore avoiding or overcoming isolation.
3. Physical activity (49% n58) – vigorous physical activities including sports were seen as a means of releasing stress.
4. Internal resources (47% n55) – taking a positive approach, identifying strengths and reinforcing determination to cope. This involved an element of taking control rather than of being a victim.
5. Connecting to the original culture (17% n20)
6. Nothing helped (14% n16)

NON-USEFUL COPING STRATEGIES INCLUDE:

1. Not talking about it (13% n15)
- 2 Substance use (8% n9)

(Source: Info Sheet 3, The Social and Emotional Wellbeing of Young People, YANQ and QTMHC, 2000)

QTMHC also attended the public launch of the Queensland Health Multicultural Policy Statement and Queensland Health Language Services Policy Statement. These Statements documents how Queensland Health will respond to the Government's multicultural policy commitments and takes the mandated principles and embeds them into core Queensland Health processes and practices. The Policy Statement provides an illustrated Multicultural Health Framework diagram to give guidance to Queensland Health's services and units for the formulations of plans in specific health service and population health environments.

The approach is not prescriptive. The breadth and intensity of the service response will vary according to the degree of cultural diversity and health need in different parts of the state. The key sections are: 1) Principles; 2) Health Service Consumer Outcomes; 3) Statement of responsibilities; 4) Implementation Process and 5) Multicultural Health Planning Options.

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Enquiries and bookings to the Editor on (02) 9840 3381

African Communities Development Initiative for the Promotion of Mental Health

A significant and regular component of the Transcultural Psychiatry Unit's function is to develop and facilitate culturally-sensitive mental health promotion initiatives among ethnic communities living in rural and metropolitan areas.

One of the current activities in which the Unit has been jointly involved is the African Communities Development Program in Mental Health. The Multicultural Access Unit and Transcultural Psychiatry Unit have developed a community-driven, 'train-the-trainer' mental health promotion package for men and women of the different African Communities. The program was launched earlier this year by Professor George Lipton, Chief Psychiatrist and General Manager, of the Mental Health Division. The objective is to empower participants to disseminate accurate information about mental health issues to members of their respective communities in a culturally and linguistically sensitive manner. There was a consensus agreement among participants that bringing the different African communities together under the banner of a 'train-the-trainer' mental health initiative is quite unprecedented in metropolitan Perth – especially with so many men and women participating throughout the duration of the program.

Approximately 5000 Africans reside in Western Australia. The majority of whom come from East Africa, or the 'Horn of Africa'. Many arrived during the period 1991-1996. However, the African communities in metropolitan Perth may still be described as one of the 'small and emerging communities'. Compared with other CALD communities, the African communities have relatively low overall numbers, but a high growth rate. Because of the comparatively low numbers of African community members – in comparison with other CALD communities – much of the mental health promotion initiatives have tended to overlook members of the African communities. Anecdotal evidence suggests that African communities have a significant 'untreated' prevalence of mental illness. However, compared with those CALD communities which are shown in the literature to be more often targeted for

mental health promotion and research initiatives (eg. Bosnian, Croatian, Polish, Vietnamese etc.) the culturally and linguistically appropriate resources available to the African communities for facilitating their understanding of mental illness and other aspects of mental health issues are still underdeveloped and not easily accessible. Our extensive search of the literature and databases, in addition to conducting a nationwide survey across all relevant agencies, have led to the conclusion that translated material on mental health and mental illness are widely available in many other languages (eg. Chinese, Vietnamese, Serbian etc) but there is virtually no mental health related material available in the African languages (eg. Amharic, Tigrinya, Somali etc.) Moreover, it is often difficult to find interpreters who speak the appropriate African language or dialect to assist African communities members in utilizing mental health services. In addition, the availability of African background counsellors, general practitioners, and mental health professionals, is significantly limited.

DEVELOPMENT OF THE PROGRAM

The development process for the program involved community consultation with all community members rather than a reliance on the opinions and thoughts of 'key representative voices'. This ensured that contents of the package developed, are relevant for the respective communities. MAU and TPU staff were careful not to misrepresent the intention of this program. For the goal was not to train participants to be mental health professionals but to train participants to be a conduit for information flow on mental health issues for their communities. It was therefore important that participants had accurate expectations from their participation in this program. From the outset, expectations of program organizers were stipulated and agreed upon by prospective participants. However, an important aim to be achieved from each

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African Communities Development Initiative for the Promotion of Mental Health continued

session was to familiarize participants with the risk factors to mental illness and highlight the protective influences that would assist in maintaining mental health.

CONDUCTING THE PROGRAM

The program was conducted over 7 weeks. Gender sensitivity was an important consideration for the communities. To address this, sessions were separately conducted for men and women participants.

This arrangement allowed participants to freely express, question, or comment on sensitive mental health issues among same- gender fellow participants. Sessions were conducted by staff of the Transcultural Psychiatry Unit and guest clinicians, identified for their expertise in a given topic, and facilitated by staff of the Multicultural Access Unit. It was also considered essential, however, that speakers were

chosen not only because of their specific expertise, but also for their good understanding of the impact of culture on perception of mental illness – through either work experience or their own migration/ acculturation experience. We maintain that such an understanding would facilitate speakers in structuring the content of the message and the style of delivery at a level that may bridge the cultural gap of communication concerning mental health, with the audience. Through the network of clinicians with whom the Transcultural Psychiatry Unit has developed, we were fortunate to locate practitioners who meet these essential criteria which thus enabled participants to quickly relate to the message conveyed, thus enhancing their receptiveness to its content.

The assembly of different African cultures in these sessions provided a detailed insight into the each culture's conceptualization of mental health and mental illness.

Furthermore, it allowed each participant to discuss and share their culture-bound perception of specific mental disorders such as depression, schizophrenia and other disorders and issues arising from the course. The high number of men participating was, in itself, a very good achievement for this program. The opportunity was afforded to explore different opinions and priorities between men and women with respect to each gender's perception of mental health, mental illness, and the culturally- influenced coping strategies that differ between the genders.

ANTICIPATED OUTCOME

Consistent with the aims of the program organizers, African communities members agreed that such a program should not be a 'one-off'. In view of this, a second phase to this program is envisaged which will include development of relevant translated resources and enhancing the availability of such material for use of by the newly-trained trainers in their role as mental health resource person and, for distribution among their communities. Having now provided participants with background knowledge to mental health issues identified as relevant for their communities, a further proposed component of the second phase is to provide a more focused training program to enable participants to work more effectively with their respective communities.

The program's efficacy will be demonstrated by participants' subsequent endeavours to utilize the newly acquired skills and knowledge to carry out their role as the 'mental health resource person' for their respective communities. With ongoing support from the Transcultural Psychiatry Unit and the Multicultural Access Unit, participants who have followed the program will be able to assist in allaying fears, and dispelling misconceptions of mental illness and mental health services among members of their communities, in a manner that will transcend the barriers of language and culture.

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Evaluation of the Bilingual Case Management Program

The Victorian Transcultural Psychiatry Unit is about to publish the final report of the evaluation of the Bilingual Case Management (BCM) Program in the Western Region of Melbourne. The report describes the implementation and evaluation of the program, which was established in 1996 in accordance with the Department of Human Services policy 'Victoria's Mental Health Service: Improving services to people of non-English speaking background' (Department of Human Services, 1996).

Eleven bilingual staff (who speak Croatian, Greek, Italian, Macedonian, Turkish and Vietnamese) are employed in case management positions in community teams at the four Area Mental Health Services in the Region. The staff are from psychiatric nursing, occupational therapy, social work and psychology backgrounds. Their roles include case management with a focus on clients from the same ethnic background as well as other ethnic backgrounds, joint case management, secondary consultation to other staff, family education and support, and community education.

The evaluation, conducted by the Victorian Transcultural Psychiatry Unit, consists broadly of two parts. The first describes the implementation of the program, and compares its planned operation with the 'real-life' practice. The second part of the evaluation considers the impact of the program on services and NESB clients. At the service level we examined community work, interpreter use, accessibility of services to NESB people, and general cross-cultural issues. We investigated the impact for clients of having a case manager of the same background on medication management, service use, views about cross-cultural sensitivity and general satisfaction, and level of social functioning.

The report is expected to be published in mid-July.

SOON TO BE RELEASED

"Bibliography of Multilingual Mental Health Instruments"

What is it?

An initiative from the Victorian Transcultural Psychiatry Unit, it is a compilation of psychological / psychiatric assessment tools in other languages than English, aimed at researchers and clinicians to access research using multi-lingual instruments, with the hope that clinical service provision and clinical research will be facilitated.

How to use it?

If a copy of any instrument is required then this may be requested from the authors of the papers listed in the bibliography. Each published article nominates a researcher for correspondence.

Where to obtain it?

The compilation is available at the Victorian Transcultural Psychiatry Unit Website, at the following address:
<http://www.vtpu.org.au>
And will be shortly available as a publication.

The VTPU is in the process of designing it's own website the address will be:

<http://www.vtpu.org.au>.

The site will also include the Journal for Culture & Mental Health (JCMH), if you would like to be on the mailing list please send requests to:

v.tittl@medicine.unimelb.edu.au.

Those interested in obtaining a copy of the Bilingual Case Management Program & Bibliography of Multilingual Mental Health Instruments should contact:

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FUNDING BOOST FOR NSW MENTAL HEALTH SERVICES

The NSW Minister for Health, Mr Craig Knowles, has announced a \$107.5 million increase in recurrent expenditure for mental health services over the next three years.

This will include an expansion of the NSW Transcultural Mental Health Centre, servicing the needs of people of our multicultural community.

NEW BOOK ON ADOLESCENT MENTAL HEALTH

The Transcultural Mental Health Centre's latest monograph, *Deeper Dimensions – Culture, Youth and Mental Health*, will be launched on July 26 at the New Childrens Hospital.

Edited by Marie Bashir AO and David Bennett AO, the book is the seventh in the Centre's Culture and Mental Health series. It begins with a comprehensive literature review and goes on to cover many of the key issues surrounding mental health and the youth of non-mainstream cultures in Australia.

For further information contact Dr Ian McIndoe, Publications Officer, on (02) 9840 3800.

CONSUMER APPOINTMENT

Claudio Silva, a member of the Mental Health Consumer Action Group, has been appointed to serve a two-year term with the NSW Consumer Advisory Group (CAG). The CAG is the peak advisory group that oversights and monitors the Second National Mental Health Plan at the state and local level.

'This is a very important position for consumers because the Consumer Advisory Group has meetings with the Director of Mental Health and acts as an advisory group to the Minister of Health,' Claudio said.

'I will be raising a number of issues on the CAG, including the under utilisation of mental health services by some communities, the lack of the use of interpreters by GPs,

social workers and other professionals, the lack of sensitivity to issues facing consumers, and the tendency to look at developments in mental health from an Anglo-Saxon perspective.'

'One major problem with mental health services today is that they underestimate the importance of warmth and trust and simply talking to consumers,' Claudio said. 'When I visit consumers in hospital I am amazed how responsive consumers are when you spend five or ten minutes talking to them. They don't want to talk about medication and things like that, they simply want to have some human contact.'

HEALTH AND THE JEWISH COMMUNITY

A wide range of health issues relevant to the Jewish community was discussed at a Sydney conference on May 15. The conference was a collaborative venture between Multicultural Health South Eastern Sydney Area Health Service, Jewish Care and the Wolper Jewish Hospital and featured a range of eminent speakers from Australia and overseas.

Speakers included Dr Foster, a consultant psychiatrist, who gave an insight into second generation Holocaust survivors, the long-term effects of trauma and the impact on the children of survivors and intra-family relationships. He compared the American and Australian experiences and the need for social recognition and validity to be given to the experiences of survivors, referring to Australia's acceptance of cultural diversity as a positive factor in their ability to rebuild their lives.

Associate Professor Maurice Eisenbruch, of the University of New South Wales, spoke about the need to derive lessons from the Jewish experience of the Holocaust and apply them to the health of other post-Holocaust refugee survivors of genocide and human rights abuses. He referred particularly to the Cambodian people who suffer the massive health consequences of Acultural bereavement, which is best treated by the restoration of cultural traditions and rituals to help survivors connect with the past they have lost.

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TIME IN AUSTRALIA

Kliwer and Ward (1988) found a positive relation between length of residence of immigrants in Canada and the degree of convergence of immigrant suicide rates to that of the Canadian-born rates.

There are mixed reports regarding the influence on rates of time spent in Australia. Burvill et al. (1982a) in an analysis of their 1961-70 suicide data failed to uphold their hypothesis that the longer immigrants lived in Australia the more their suicide rates would approach those of the Australian-born. By contrast Hassan (1995) found immigrant suicide rates for the years 1968-80 tended to decline with length of residence in Australia, except for those from Poland and Russia whose rate increased significantly with length of residence for both males and females. Possibly the differing times of residence in Australia used in the data analysis 0-5, 6-16, 17 and older by Burvill et al. (1982a) and 1-9, 10 years and more by Hassan (1995), and the different period 1961-70 v. 1968-80, may have influenced these different findings. A third possibility is that Hassan's data appeared not to have been age standardised, in so far as no mention was made of such, whereas that of Burvill et al. was standardised.

Whereas most of the immigrant suicide studies have included multiple COB in countries or groups of countries, two papers have focused specifically on immigrants from Britain and Eire. Burvill, McCall, Reid and Stenhouse (1973b) found that the percentage distribution of methods used by the immigrants from England and Wales during 1962-66 was more akin to that of the Australian-born rather than in their COB, and did not vary significantly with time in Australia. However the latter differed for certain specific methods, e.g. male immigrants from England and Wales used guns with a corresponding reduction in use of domestic gas,

approaching nearer the Australian methods with increased time in Australia. Burvill, McCall, Woodings and Stenhouse (1983a) found higher suicide rates for English, Scots and Irish immigrants during 1961-70 than those in their COB, especially among the Irish. These data highlighted differences in ascertainment in the various countries, most prominent in Eire. Burvill, McCall, Stenhouse and Woodings (1982b) found that deaths classified as 'undetermined' after the introduction of that category in the ICD-8 in 1968, had previously been classified as accidental deaths, especially deaths from poisoning.

CHANGES IN THE 1980'S

Since the early 1980's there have been four prominent changes in the general pattern of suicide in Australia; viz.

- (i) big changes in male rates, especially in young males;
- (ii) increased rates in the 'very old', i.e. 75 years of age, giving a bimodal pattern to male age specific rates over the last 15 years;
- (iii) an increasing male:female ratio, mainly due to increasing male rates and fairly static female rates; and
- (iv) changes in the method of suicide.

Furthermore, over this period the migration pattern to Australia has changed considerably with proportionately fewer U.K. and European immigrants, and more non-European immigrants especially from Asia. Unfortunately there is not much published data relevant to this period. There have been two New South Wales studies of differential immigrant suicide rates in 1985-94 between urban and rural areas by Morell et al. (1999) and by Taylor, Morell, Slayter and Ford (1998) on the influence of socio-economic status on immigrant rates. A further two papers have been written by Burvill on suicide rates of immigrants during the twelve year period 1979-90 (Burvill, 1995, 1998), the former paper being specifically focussed on the elderly.

The next section draws on these papers and unpublished data for that 1979-90 period to examine to what extent these recent changes in suicide patterns have been reflected in the immigrant suicide data.

The situation over this period can be summarised thus:

RATES

Aggregated immigrant suicide rates have largely followed the increased Australian-born male rates and the relatively flat female rates over this period, and have been slightly higher than the rates for the Australian-born each year with only a few exceptions (Table 4).

TABLE 4
ANNUAL MALE : FEMALE RATIO OF
AGE STANDARDISED SUICIDE
RATES BY COB 1979-90

| Country of birth | | |
|------------------|-----------|----------|
| Year | Australia | Migrants |
| 1979 | 2.7 | 2.3 |
| 1980 | 3.1 | 2.8 |
| 1981 | 3.1 | 3.2 |
| 1982 | 3.2 | 2.4 |
| 1983 | 3.5 | 2.5 |
| 1984 | 3.4 | 3.1 |
| 1985 | 3.9 | 3.1 |
| 1986 | 3.6 | 3.1 |
| 1987 | 4.0 | 3.4 |
| 1988 | 3.8 | 4.0 |
| 1989 | 3.8 | 4.0 |
| 1990 | 4.7 | 3.2 |

Morell et al. (1999) found particularly high rates in immigrants in rural New South Wales for the period 1985-94. There was a similar heterogeneous pattern of European immigrant rates over this period 1979-90, as over the 1961-70 period, with a 14-fold male difference and a 12-fold female difference between the highest and lowest age standardised rates, with the

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Australian-born having intermediate rates (Table 5).

Of the eleven Asian countries studied, all but Korea had low male rates. By contrast in females five immigrant groups had rates considerably higher than the Australian-born (Table 3). Similar findings were made by Morell et al. (1999) for the ten years 1985-94 for the whole of New South Wales.

RATES IN THE YOUNG

The most dramatic change in the pattern of suicide in Australia over this period has been the marked increase in young male suicides since the mid 1980's, similar to that reported for most, but not all, European and Western countries (Barracough, 1988). Table 6 lists the age standardised suicide rates of younger males by COB for the years 1979-90 listed in rank order of rates for all age groups. Young male immigrant rates showed a heterogeneous pattern. With the exception of Poland and the former Yugoslavia, immigrants from countries with higher overall rates than the Australian-born had similar high young male rates, with exceptionally high rates in the Irish-born. However there were not similar increased young male rates in those immigrant groups with overall low suicide rates in their COB, namely those from Asia, the Middle East and Southern European countries. Rates for young females, both Australian-born and immigrants, generally remained flat during this period.

RATES IN THE ELDERLY

Whereas suicide rates in the elderly have progressively decreased in the Australian population as a whole since 1996, rates in European immigrants of both sexes began to increase with age from 45 years onwards with exceptionally high male rates in those aged 75 years and older (the 'old old'). This included the Italian-born, who are the most populous non-English speaking immigrant group in Australia. Table 7 lists the age standardised suicide rates in six grouped COB's in those aged 65 years and older for the years 1979-90. Whereas Asian male immigrant rates were low for most ages, there has been a very marked increase in rates from 65 years of age onwards rising to rates higher than those born in Australia and the British Isles. There has been a similar but smaller rise in elderly female rates.

TABLE 5

AGE STANDARDISED SUICIDE RATES BY COB 1979-90*

| Place of birth | Rates (a) in Australia 1979-90 | | Rates (b) in country of birth | | Ratio of (a):(b) | | Ratio of (a) Australian born pop. | |
|-----------------|--------------------------------|------|-------------------------------|------|------------------|------|-----------------------------------|------|
| | M | F | M | F | M | F | M | F |
| Australia | 25.4 | 7.2 | — | — | — | — | 1.0 | 1.0 |
| Eire | 62.8 | 14.2 | 20.0 | 6.4 | 3.1 | 2.2 | 2.5 | 2.0 |
| Scandinavia | 54.8 | 12.9 | 33.0 | 13.6 | 1.7 | 0.9 | 2.2 | 1.8 |
| Hungary | 52.4 | 25.3 | 73.4 | 25.4 | 0.7 | 0.99 | 2.1 | 3.5 |
| Austria | 44.2 | 22.5 | 42.5 | 13.8 | 1.04 | 1.6 | 1.8 | 3.1 |
| Germany | 39.9 | 15.3 | 32.3 | 13.5 | 1.2 | 1.1 | 1.6 | 2.1 |
| Yugoslavia | 31.9 | 11.1 | 28.3 | 11.7 | 0.9 | 0.95 | 1.3 | 1.6 |
| New Zealand | 31.2 | 8.2 | 29.6 | 7.1 | 1.05 | 1.2 | 1.3 | 1.1 |
| Poland | 29.3 | 13.2 | 32.8 | 5.8 | 0.9 | 2.3 | 1.2 | 1.8 |
| Scotland | 29.0 | 6.8 | 20.0 | 6.0 | 1.5 | 1.1 | 1.2 | 0.95 |
| USSR | 28.7 | 13.5 | — | — | — | — | 1.1 | 1.9 |
| Netherlands | 26.6 | 6.2 | 14.6 | 8.7 | 1.8 | 0.7 | 1.1 | 0.9 |
| USA | 25.7 | 9.7 | 25.8 | 6.1 | 1.0 | 1.6 | 1.01 | 1.4 |
| England & Wales | 24.4 | 6.5 | 15.1 | 4.2 | 1.6 | 1.5 | 0.96 | 0.91 |
| Italy | 16.2 | 4.4 | 13.6 | 4.9 | 1.2 | 0.9 | 0.7 | 0.6 |
| Greece | 12.5 | 8.1 | 6.8 | 1.9 | 1.8 | 4.3 | 0.5 | 1.1 |

* Unpublished data

TABLE 6

AGE STANDARDISED SUICIDE RATES YOUNGER MALES 1979-90*

| Country of birth | 15-19 | 20-24 | 25-29 | 30-34 |
|------------------|-------|-------|-------|-------|
| Australia | 15.1 | 31.4 | 30.8 | 25.4 |
| Eire | 84.7 | 93.6 | 78.1 | 54.4 |
| Scandinavia | 43.1 | 54.9 | 80.7 | 76.8 |
| Czechoslovakia | 0 | 121.9 | 24.1 | 95.5 |
| Hungary | 0 | 47.6 | 63.8 | 46.1 |
| Austria | 37.5 | 44.9 | 55.4 | 69.1 |
| Germany | 5.1 | 58.7 | 48.3 | 35.3 |
| Yugoslavia | 4.4 | 27.9 | 25.6 | 26.1 |
| Poland | 0 | 12.2 | 28.4 | 29.3 |
| Scotland | 23.1 | 38.1 | 34.7 | 23.6 |
| Netherlands | 29.1 | 28.8 | 28.0 | 25.2 |
| England & Wales | 15.8 | 30.3 | 31.1 | 26.4 |
| Italy | 0 | 13.9 | 11.3 | 16.1 |
| Greece | 4.7 | 11.2 | 13.3 | 8.1 |
| New Zealand | 22.8 | 42.1 | 32.6 | 27.8 |
| South Africa | 27.8 | 76.5 | 32.0 | 23.4 |
| Canada | 9.5 | 35.2 | 16.8 | 65.2 |
| USA | 10.3 | 23.2 | 41.5 | 20.7 |
| Hong Kong | 5.0 | 12.5 | 24.9 | 18.9 |
| India | 0 | 44.2 | 16.9 | 25.9 |
| Malaysia | 2.8 | 14.9 | 21.0 | 13.9 |
| Vietnam | 10.7 | 17.2 | 9.5 | 15.3 |

* Unpublished data

MALE:FEMALE RATIO

The male:female ratio of age standardised suicide rates has been consistently higher in the Australian-born than in immigrants for all years 1979-90 except 1981, 1988 and 1989 (Table 8). In both groups there has been an increasing M:F ratio over this period from 2.7:1 (Australian) and 2.3 (immigrants) in 1979 to 4.7 (Australians) in 1990 and 4.0 (immigrants) in 1988-89. Generally it is considered that the very large increases in young male rates have been the major contributor to this increased M:F ratio. Suicide numbers are too small to analyse the annual M:F for immigrants from individual countries of birth. The M:F ratio of ASR's for the 12 years varied considerably between grouped countries of birth, with the highest ratio in those from Africa, the Middle East and Oceania, and the lowest in those from Asia and Europe (Table 9). The ratio for the Australian-born was intermediate and very similar to that from North America, the United Kingdom and Eire.

METHODS

During 1979-90 the four most common methods of suicide in males in Australia were overdose, use of firearms, hanging and poisoning by gas other than domestic gas. The latter invariably means using carbon monoxide from motor vehicles. In males the use of firearms was the most common method used by those born in Australia and North America, but not very common in other immigrant groups and lowest in Asians. Hanging was the most common method used by immigrants from Europe, the Middle East and Asia. Overdose was not a predominant cause of suicide in any of the immigrant groups.

In females overdose was the commonest method used by all except Asians, in whom hanging was most common. In all the other groups, hanging was the second most common method. Use of firearms was infrequently used by all immigrant groups. Drowning and jumping from a high place were relatively common methods used by those from the Middle East.

RANK ORDERING OF IMMIGRANT SUICIDE RATES

The statistically significant correlation between the rank ordering of suicide rates in immigrants with that in their COB in earlier studies was shown by Sainsbury and Barraclough (1968) in the United States of America, by Whitlock (1971), Lester (1972), Burvill et al (1982a), Hassan (1995) and Burvill (1998) in Australia, and by Kliewer and Ward (1988) in Canada. That is, immigrants from countries with high suicide had high suicide rates in Australia and vice versa.

TABLE 7

SUICIDE RATES IN COB GROUPINGS, AGED 65+ YEARS, 1979-90

| Country of birth | Male | Female | M : F |
|------------------|------|--------|---------|
| Europe | 43.1 | 17.4 | 2.5 : 1 |
| Asia | 31.0 | 12.2 | 2.5 : 1 |
| Oceania | 31.0 | 7.5 | 4.1 : 1 |
| Australia | 28.2 | 7.4 | 3.8 : 1 |
| UK and Ireland | 27.3 | 7.7 | 3.5 : 1 |
| Middle East | 23.6 | 6.7 | 4.8 : 1 |

TABLE 8

ANNUAL MALE : FEMALE RATIO OF AGE STANDARDISED SUICIDE RATES BY COB 1979-90

| Year | Australia | Migrants |
|------|-----------|----------|
| 1979 | 2.7 | 2.3 |
| 1980 | 3.1 | 2.8 |
| 1981 | 3.1 | 3.2 |
| 1982 | 3.2 | 2.4 |
| 1983 | 3.5 | 2.5 |
| 1984 | 3.4 | 3.1 |
| 1985 | 3.9 | 3.1 |
| 1986 | 3.6 | 3.1 |
| 1987 | 4.0 | 3.4 |
| 1988 | 3.8 | 4.0 |
| 1989 | 3.8 | 4.0 |
| 1990 | 4.7 | 3.2 |

TABLE 9

MALE : FEMALE RATIO OF AGE STANDARDISED SUICIDE RATES BY GROUPED COB 1979-91

| Country of birth | ASR Suicide | | |
|------------------|-------------|--------|-----|
| | Male | Female | M:F |
| Africa | 30.4 | 6.4 | 4.7 |
| Middle East | 1.7 | 3.4 | 4.0 |
| Oceania | 30.4 | 7.6 | 4.0 |
| Australia | 25.4 | 7.2 | 3.5 |
| UK and Eire | 26.7 | 6.9 | 3.9 |
| North America | 22.6 | 7.9 | 2.9 |
| Europe | 26.1 | 9.6 | 2.7 |
| Asia | 14.6 | 7.1 | 2.1 |

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Table 10 shows Spearman rank correlations between the rank ordering of standardised suicide rates of immigrants in Australia and of rates in their COB for eleven United Kingdom and European countries, selected on the basis that the number of their suicides were sufficiently high for statistical analysis. There were statistically significant high correlations;

(i) between rates in their COB in Europe and in Australia in each of the two periods 1960-71 and 1979-1990,

(ii) between the immigrants in Australia during these two periods, and

(iii) between their COB's in the two periods (Burvill et al., 1982a, Burvill, 1998).

Furthermore when, for each of these periods, a further five countries were added to the eleven European countries, namely Malta, New Zealand, Nordic countries, U.S.S.R. and the United Arab Republic, the Spearman rank correlations were again highly statistically significant.

TABLE 10
RANK CORRELATIONS OF AGE
STANDARDISED SUICIDE RATES BY
COB

| Ranked rates | | Correlation | Stats. Signif. |
|-------------------|---|-------------|----------------|
| 1960-71 migrants: | M | 0.89 | < 0.01 |
| COB | F | 0.80 | < 0.01 |
| 1979-90 migrant: | M | 0.82 | < 0.01 |
| COB | F | 0.70 | < 0.05 |
| Migrant rates | M | 0.72 | < 0.05 |
| 1960-7:1979-90 | F | 0.78 | < 0.01 |
| COB rates | M | 0.85 | < 0.01 |
| 1960-7:1979-90 | F | 0.67 | < 0.05 |
| Migrant rates | M | 0.89 | < 0.01 |
| 1960-71:1979-90 | F | 0.72 | < 0.01 |
| (16 countries) | | | |

ATTEMPTED SUICIDE

The literature on attempted suicide in immigrants is sparse. Burke (1976) reviewed the evidence which suggested the immigrant rather than non-immigrant populations may be more predisposed to attempt suicide. There were a number of early studies of attempted suicide in immigrants in Australia which reported conflicting results. Curiously the early papers in Australia were in the 1960's predating the immigrant suicide papers. These all pertain to data in a particular state rather than to the whole of Australia. All these studies can be criticised on a variety of methodical grounds.

Buckle et al. (1965) found no difference in rates of attempted suicide between non-immigrants and immigrants in Melbourne, whereas Gold (1965) found in Northeastern Tasmania that migrant suicide rates were nearly twice those expected.

Krupinski, Stoller and Polka (1967) reported a significantly high proportion of non-British female immigrants admitted with attempted suicide to mental health institutions in Victoria. Edwards and Whitlock (1968) concluded that immigration was not a significant cause of attempted suicide, although they did find a significantly lower proportion of immigrants from Britain. Burvill (1975) found high male age standardised immigrant rates of attempted suicide compared with the Australian-born in Perth for the two years 1971-72.

Burvill, Armstrong and Carlson (1983b) examined the rates and methods of attempted suicide in Perth, Western Australia for the 10 year period 1969-78 (Table 11). Although there was a wide difference between the rates of the various immigrant groups examined, the difference between the highest and lowest rates, 4.6 fold in males and 2.8 fold in females, were much less than that shown for suicide rates. There were noticeable differences in the rank

TABLE 11
AGE STANDARDISED ATTEMPTED
SUICIDE RATES IN PERTH BY COB
1969-78

| Country of Birth | ASR | |
|------------------|-------|--------|
| | Male | Female |
| New Zealand | 213.7 | 359.4 |
| Scotland | 180.3 | 265.2 |
| Germany | 170.8 | 292.1 |
| Ireland | 168.9 | 332.8 |
| England & Wales | 137.2 | 233.2 |
| Australia | 131.4 | 253.1 |
| Netherlands | 104.6 | 241.8 |
| India & Pakistan | 81.4 | 169.4 |
| Greece | 77.8 | 128.9 |
| Yugoslavia | 57.8 | 196.2 |
| Italy | 49.5 | 157.5 |
| Poland | 45.4 | 207.0 |

ordering of COB's. Whereas for males seven COB's had higher rates than the Australian-born, only the rates of immigrants from New Zealand and Scotland were significantly higher. For females four COB's had higher rates than the Australian-born and more COB's had lower rates. Those from New Zealand had significantly higher rates and those from Greece, Italy and India and Pakistan significantly lower rates. There was a significant correlation between the rank ordering of rates of COB's of males and females. It was not possible at the time of the study to compare the immigrant rates with those of their country of birth. Methods of attempted suicide did not differ significantly between immigrants and the Australian-born, being predominantly overdosage.

SOCIAL FACTORS

Very little of these differential suicide rates in immigrants can be explained in purely biological terms. It is generally accepted that no single cause or group of causes can account for the level of suicide rates (Stengel, 1969). Immigration is often associated with major stress before, during and for a considerable time after the event, and suicide is one manifestation of the

failure to adjust to these stressful factors (Kliewer, 1991). Since the publication of Durkheim's (1951) seminal study it has been customary to look to the causation of suicide in predominantly sociological or socio-cultural terms.

Whitlock (1971), in the first major paper on migration and suicide in Australia, speculated on the various sociological factors involved. He discussed his finding in terms of the mental health of immigrants, both before and after arrival in Australia, the influence of drinking habits, and the degree of acculturation and social support experienced by the different racial groups. He referred to suicide as a culture bound phenomenon.

Burvill et al. (1982a, 1983b) used the model of Murphy (1977) to examine both immigrant suicide and attempted suicide rates. This model emphasised the importance of factors relating to;

- (i) the society of origin,
- (ii) the migration itself and
- (iii) the society of re-settlement.

Hassan (1995) particularly emphasised the third of these, viz. factors operating in the society of resettlement. Suicide rates are generally higher in refugees than in non-refugees.

The effect of the description of social ties in the process of immigration and the effect of this on social integration in the host country producing a state of anomie, which Durkheim (1951) considered one of the principal causes of suicide, has been emphasised in all these papers. Hassan (1995) has also considered the suicide in terms of object-loss theory.

I will not expound on possible psychological factors in this paper, except in relation to two topics;

- (i) data regarding the correlation of rank ordering of rates with their COB's, and
- (ii) the consistently low suicide rates in some immigrant groups.

The finding of a *significant correlation*

between the rank ordering of suicide rates of immigrants in their COB with that in their country of adoption must be one of the most robust research findings in the psychiatric literature, or certainly in the literature pertaining to suicide. This is, immigrants from countries with high suicide rates have high rates in their new country, and vice versa.

The importance of the attitude towards suicide that immigrants unwittingly bring with them from their own country has been emphasised by Whitlock (1971), Burvill et al. (1982a, 1983b), Kliewer & Ward (1988), Kliewer (1991) and Burvill (1995). By contrast Hassan (1995) placed particular emphasis on factors encountered in the host country. My own bias is towards placing major emphasis on factors in their own COB. For many immigrants this would have been in their early formative years. The suicide rate in their COB is the single most important factor influencing their suicide rate in their host country. I believe this would be a very fruitful area for further research. Blazer, Bocher and Manton (1986) in their study of suicide in the elderly in the United States of America, postulated that specific birth cohorts who had suffered increased sociocultural stress in early life leading to higher suicide rates continued to experience these higher rates relative to other birth cohorts throughout most of their life-cycle. Murphy and Wetzel (1980) have also suggested that early life experiences of all nominated cohorts sustain an enduring effect on suicide rates, but in subsequent papers they acknowledged that evidence to date for this assertion was lacking (Murphy, Lindesay & Grundy, 1986; Wetzel, Reich, Murphy, Province & Miller, 1987).

The low suicide rates were in immigrants from Asia, the Middle East and Southern Europe, all areas in which traditional values, strong family influences and/or religious values are

prominent and all factors opposite to those producing Durkheim's described state of anomie. Low suicide rates of the Southern European immigrants has also been recorded in the United States (Sainsbury & Barraclough, 1968) and Canada (Kliewer, 1991). Countries with a strong Muslim population, such as those of the Middle East and some Asian countries, have recorded very low suicide rates. Similar very low rates have been reported in Malays (Muslim religion) compared with the Chinese and Indian ethnic populations in Malaysia (Teoh, 1974) and Singapore (Ko & Kua, 1995). These immigrant groups have had low young male suicide rates over the recent period during which there have been such high rates in Australia and in most Western countries. Thus there must be some very powerful protective factors operating in these groups, which might give us food for thought in our current efforts to devise suicide preventive measures for young males, methods which to date have not been conspicuously successful.

FUTURE RESEARCH

Finally, I will finish with a few thoughts on possible future research in the area of suicide in immigrants.

A major focus of this conference is upon prevention and research ideas for the future. Personally, I am not impressed that efforts at preventing suicide to date have been successful or are based on good scientific foundations. We are still floundering in the dark to produce a convincing blueprint for preventing suicide. Study of suicide in immigrants provides a good research programme for our better understanding of the causes of suicide.

All the research papers I have reviewed have been based solely on Australian Bureau of Statistics data, and have been mainly descriptive and almost all devoid of any statistical analysis other than the use of age-sex standardisation of rates and correlation coefficients. In the past this was mostly the case in

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suicide research everywhere. Fortunately recent research in suicide, both in Australia and internationally, is beginning to use modern statistical and research techniques. One of the most basic research techniques is to compare one set of data with a control group to test specific hypotheses. Comparison of immigrant suicide data with the Australian-born ideally fits into this model, and as such provides a potentially good research area for the better understanding of the causes of suicide.

The following are a few suggestions of areas one might consider. I offer them more in the spirit of focussing discussion on hypotheses to be tested rather than repetitively producing small variations on known facts, and/or spending large amounts of money on preventive programmes based on hunches, ideology and well meaning desires to do something helpful:

Continue to use *Australian Bureau of Statistics (ABS) data*, but make more extensive use of the multiple variables available in the Census data than is customary, in collaboration with other professionals such as economists using modern statistical techniques to test specific hypotheses. The ABS data contain a lot of information of interest to economists which has not been fully explored in suicide research in the Australian population as a whole, let alone in immigrants. Even socio-economic status can have differential effects in different COB's e.g. Taylor et al. (1998) in a study of suicides in New South Wales (1985-94) found that suicide rates are higher in those in low socio-economic groups in males born in Australia, English speaking countries and Asians, but not in non-English speaking European males or in females.

YOUNG MALES

Why males and not females? What are the protective factors in those immigrant groups with overall low suicide that also appears to protect young males? Why are there such high

rates both in those young males from COB's with habitually high overall rates and in the Australian-born who normally have somewhat intermediate rates? Why such high rates in young Irish immigrants?

WHY HIGHER RATES IN THE OLDER IMMIGRANTS?

Why are the rates specially high in some Asian migrant groups? Possibly there is a serious breakdown in relevant family/cultural protective factors in elderly immigrants. Is it due to greater risk of physical ill health? A Perth study showed a higher than expected rate of admission of elderly Dutch and Italian males and females with organic mental disorders, especially in those aged 75 years and older (Bruxner, Burvill & Fazio, 1996). The authors suggested that the elderly with dementia may overwhelm customary family support systems.

WHY ARE THERE HIGHER RATES IN FEMALES IN SOME ASIAN GROUPS?

Explore possible factors in the very robust findings of *rank correlations of COB's*, especially in early formative years. Are those factors mainly laid down in early years to a much greater extent than stressful factors encountered in their adopted country. This raises the importance of possibly related factors such as convergence in some groups and not others, whether or not convergence applies to Australian immigrants, and if not why not? Another important related factor is the extent of changes with time in Australia, and the interaction between these and questions such as acculturation, bearing in mind that the available Australian data on this question is somewhat contradictory.

STUDIES INVOLVING SECOND GENERATION IMMIGRANTS

Do the rates follow the same pattern as first generation immigrants?

What is the effect of intermarriage with Australian-born, and with other

second generation immigrant groups which have greatly different rates in the first generation?

What is the effect on rates of those reared as children in an atmosphere of strong adherence to the cultural traditions and language of their immigrant parents versus those with much less adherence to these factors?

What is the *relationship between attempted suicide and suicide* in high and low suicide risk immigrant groups. We know that attempted suicide rates are highest in the young especially in females, that recent rates are high in young males and that the rank ordering of COB's are quite different in immigrant suicide and attempted suicide data. ■

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This project devised a model of intervention which was consistent with currently available resources, and systematically addressed each of the issues recommended from these various sources of expertise.

PROJECT AIMS

GENERAL AIM

To enhance mental health care for young people with deliberate self harm (DSH) both in service performance and specific clinical treatment. To assess the impact of such enhancement on mental health outcomes.

SPECIFIC AIMS

1. To encourage services (currently representing different practices in response to DSH) to move along a dimension from less comprehensive, unstructured to more comprehensive structured response to episodes of DSH in young people. To quantify these changes; and to determine if such improvement in standard can be maintained once the specific support of the project is completed.
2. To determine if return rates for ongoing mental health assessment and treatment after initial crisis intervention can be improved by instituting certain procedures.
3. To determine if enhancements to service provision for young people with DSH lead to improved mental health outcomes.
4. To determine if a specific therapeutic modality, that is individual and family Cognitive Behavioural Therapy improves mental health outcomes.

METHODOLOGY

The project had two main components. The first was service focused, and was designed to enhance service provision for self harming

youth. The second component was designed to assess how effectively these service enhancements were adopted and the impact of these service enhancements on client health and behavioural outcomes.

TARGET GROUP

The target group for the project was all young people under the age of 24 years, who presented to a crisis service or emergency department following an episode of deliberate self harm.

The service enhancements were implemented in ten mental health services across the two Areas.

THE SERVICE ENHANCEMENTS

The service enhancements implemented within the project included; (1) training for staff in recognition and assessment of deliberate self harm clients, (2) the development of systems for the identification and tracking of clients, (3) the use of a 'Green Card' facilitated referral system, (4) the use of a standardised risk assessment package at initial contact, at 1 and 6 months and (5) the assessment of factors relating to client non compliance with follow-up treatment.

THE SERVICE ENHANCEMENT PROCESS

The service enhancements, which the project team identified as elements of evidenced based practice from the scientific literature were recommended to services. Those enhancements which were also identified by the individual services as priority areas were then implemented under the guidance of the project team. This guidance took the form of discussions with service directors and with clinical staff, assistance with changes to policies and procedures, development and organisation of staff development programs, facilitation of cross service and cross team communication and collection and collation of data

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informing the services about their progress. The provision of a Project Officer at each site assisted with each of these tasks.

THE ACTION RESEARCH PROCESS

The willingness and ability of each individual service to embrace change and implement improvements varied from site to site and was influenced by the culture and attitude within the team, what were current priorities for them, and what resource redirection capacity they had. As each specific difficulty was brought to the attention of the project team, the team renegotiated the terms of change required, made more concessions to local factors and provided greater degrees of encouragement. In this way from the outset the services were engaged in the change process and as each new finding came to light, every effort was made to incorporate their concerns into the next stage of the process.

PERIODIC ASSESSMENT OF CHANGE

To assess changes in the level of service provision, a "Service Activity Scale" was developed by the project team. It comprised a systematised evaluation of the presence or absence of service capacity to deliver a list of evidence based interventions to the target group. It was completed at three points over the life of the project by the service directors.

In addition to this, data was collected on clients who presented to the services and this was compared to data collected via file audits, from presentations prior to the commencement of the project.

Client health outcomes measurements occurred using a standardised assessment package designed to be administered at initial health contact, at 1 and 6 months.

RESULTS

For Aim 1 (to encourage services to

change their level of service delivery.)

All services improved their scores on the Service Activity Scale from the start of the project to the end.

For Aim 2 (to determine if return rates for ongoing mental health assessment and treatment can be improved via the use of certain procedures.)

There was an increase in the number of appropriate referrals from the Emergency Department to mental health services from 73% to 83%. The time between the crisis contact and first follow-up appointment was decreased from an average of 2.9 days to 1.9 days. Implementation of the "Green Card" facilitated referral system was found to increase client compliance with follow up from 40% to 84%.

For Aim 3 (to correlate improvements in services with better health outcomes)

The standardised Risk Assessment Package was only taken up inconsistently by providers.

A total of 565 clients were identified at the crisis contact point throughout the project.

Of these, only 143 received a standardised assessment package at the first mental health contact and only 25 received the 1 month follow-up.

These low numbers reflect the very real difficulty in achieving compliance with follow up which has already been identified in the literature. The numbers only began to improve in the final 6 months of the project. This improvement was due to many of the strategies to improve compliance with follow-up which were progressively introduced throughout the project as specific problems were identified. Thus compliance improved in the final stages of the project and a higher level of staff acceptance of the procedures towards the end of the project.

While the number of subjects

followed up was limited, those clients who stayed in treatment for a period long enough to receive the 1 month assessment, had improved on their assessment scores for depression, hopelessness and mental health status, which is indicative of progress towards achievements in Aim 3.

For Aim 4 (To Test the Effectiveness of Cognitive Behaviour Therapy)

The implementation of a cognitive behaviour therapy program was achieved only in 3 services and then only at the end of the project. Those clients (very small numbers) who did receive such a package did obtain the expected improvements in health status.

CLIENT FEEDBACK

Interviews were conducted with both attending and non attending clients. Compliance was correlated with (1) the perceived convenience of follow-up appointments, (2) the clients belief in whether counselling would help and (3) their belief in whether they would harm themselves again.

DISCUSSION/ CONCLUSION

A number of barriers prevented the project achieving some of its original goals and resulted in a shift in emphasis from a focus largely on the introduction of a specific therapeutic modality. As the project proceeded it became evident that before any therapeutic intervention could be successful, client follow up after initial presentation must be improved. A number of belief systems also needed to be overcome before major improvements could be made to service delivery. The project found that staff of Emergency Departments considered themselves ill equipped to manage the group of persons who present with DSH behaviour and at the outset of the project were of the belief that the problem should be the responsibility of the Mental Health system alone.

On the other hand, many Mental Health staff, and indeed their service systems, maintained a focus on people with psychotic and other related mental illnesses and believed themselves to be ill equipped to assist the Emergency Departments. This mis-match of priorities, beliefs and skills was a major obstacle to practical implementation of this important national priority. The bringing together of two disparate service systems, assisting them with the development of effective communication and staff training and supporting them whilst they underwent significant organisational change required a larger proportion of the projects' resources than had been anticipated and impeded or delayed the adoption of many service changes. These difficulties were experienced across a wide range of urban and rural settings and have major implications for other initiatives attempting to implement evidence based health care for Mental Health issues.

The project identified three factors associated with the achievement of widespread organisational change. These are: (1) a change system incorporating both top down (management commitment) and bottom up (clinical staff engagement) practices; (2) the presence of a key senior and influential clinical staff member (clinical driver) within each individual service to facilitate the change process; and (3) the setting of realistic objectives which are within the capacities of the services concerned. Even when all these factors were in place, not every service achieved the same degree of progress.

Services participating in the project achieved a measurable increase in identification and referral of clients to mental health services and an increase in compliance with appointments. The project identified the lack of motivation to attend follow up treatment as a priority issue in the development of a discharge plan for self harming clients. Such a plan is best encapsulated within the system

of care that the service provides as a routine. A literature review confirmed that referrals for follow up after the crisis contact must be specific, directive and timely. Most importantly they must be made at the time of discharge from crisis point. The supply of a phone number for the client to make his/her own appointment should not be classed as a satisfactory form of referral for this clinical population. A "Green Card" facilitated referral system has been previously described and proved to be highly effective and practical. Whether it has a sustainable impact on long term compliance with follow up remains to be seen.

The problem of non compliance resulted in a shift in emphasis during the life of the project. Initially, the development of a cognitive behavioural therapy intervention was planned. When it became apparent that non compliance was a major problem, the primary emphasis altered to developing systems for improving that compliance. This is the main reason why the project was unable to fully assess the effectiveness of a CBT intervention. From a public health perspective, the problem of non compliance with follow-up treatment must be considered a priority issue. Further research which has as a primary aim, the development of clinical intervention programs should not be considered as a national or local priority.

The interviews with attenders and non attenders which were used to address the issue of understanding the compliance problem, provided evidence that there is a powerful wish on the part of the group and their families to deny the persisting dangers following a suicide attempt. This rationalisation of the action after the event may serve to falsely reassure service providers that there is no great problem, and with this attitude, the delivery of interventions known to be efficacious, will remain illusory.

Developing evidence based guidelines in relation to DSH behaviour is a challenge. An equal challenge is implementing the strategies in the real world of generic health care. Even more of a challenge will be the measurement of health outcomes correlated with these changes in practice. Each stage has been demonstrated within this project to take significantly longer and to encounter significantly more resistance than was expected. Nevertheless, with persistence, major changes have been brought about and the methodology used, largely based on Action Research has proved to be effective.

The Project Management Team could not ensure that systemic analysis and collation of data occurred - unless they actually completed the tasks themselves. This did not accord with the aims of the project because it would not have led to sustainable service delivery or clinical practice change. The balance between persuading services to cooperate in the best interests of client care, and the necessity to obtain sufficient information for the useful evaluation of the project was a constant concern within the project team. This should be considered an important issue in future system wide evaluation of organisational change. Feedback from a number of National Youth Suicide related projects where the project team was directly responsible for data collection or for delivering a clinical intervention has revealed that both the project intervention and data collection ceased with the conclusion of the project. Their data collection may have been more comprehensive than this project but sustainable organisational change did not appear to have occurred. ■

of suicide of immigrants are more closely aligned with the rates in the country of origin than with the rates of the Australian-born (Burvill et al., 1973; Burvill et al., 1982; Hassan, 1995; Kliewer & Ward, 1988; McDonald & Steel, 1997; Whitlock, 1971). Using suicide rates reported to the World Health Organisation, McDonald & Steel (1997) showed that the rank correlation coefficient (Kendall's tau-b) between suicide rates for immigrants in NSW and those reported from the country of birth were large and significant for females (tau = 0.61, $p < 0.01$) and males (tau = 0.70, $p < 0.001$). These findings support earlier research showing that those immigrant groups with high suicide rates in Australia also had high rates in their country of origin. Similarly, those with low rates in Australia had low rates in their country of origin. This finding is illustrated in table 1 from McDonald & Steel (1997).

Another finding that has received some support is that the rates of suicide amongst immigrant groups in Australia appears higher than in the country of origin (Burvill et al., 1973; Burvill et al., 1982; Hassan, 1995; Whitlock, 1971). This finding appears to be particularly relevant to females. Calculations on data published by Burvill et al (1982) reveals an increase in the relative rate of female suicides for immigrants from the majority of countries examined including Austria, Poland, Czechoslovakia and Hungary. A similar increase in suicide rates amongst females was also reported by McDonald & Steel (1997), with the effect being most marked for females from Austria, Poland, Czechoslovakia and Greece. A more deleterious effect of migration on females than on males has also been reported in Canada as well as England and Wales (Kliewer & Ward, 1988). Some possible reasons to account for this differential effect of migration are proposed by Kliewer and Ward (1988). These include the decision to migrate often being made by the man, so that the women is less aware of, and less prepared for, the difficulties that may be encountered in the country of resettlement. They also suggest that immigrant women more often experience a marked drop in occupational and income status than males.

The methods of suicide also show significant variety (Burvill et al., 1982; Whitlock, 1971). Generally, the choice of method is believed to be influenced by a number of factors including availability, convenience and social and cultural norms (Bille-Brahe & Jessen, 1994). In Australia there appears to be a decline in the use of violent

Figure 1b Relative Risk of Suicide by Female NSW Residents by Country of Birth (1970 to 1992)

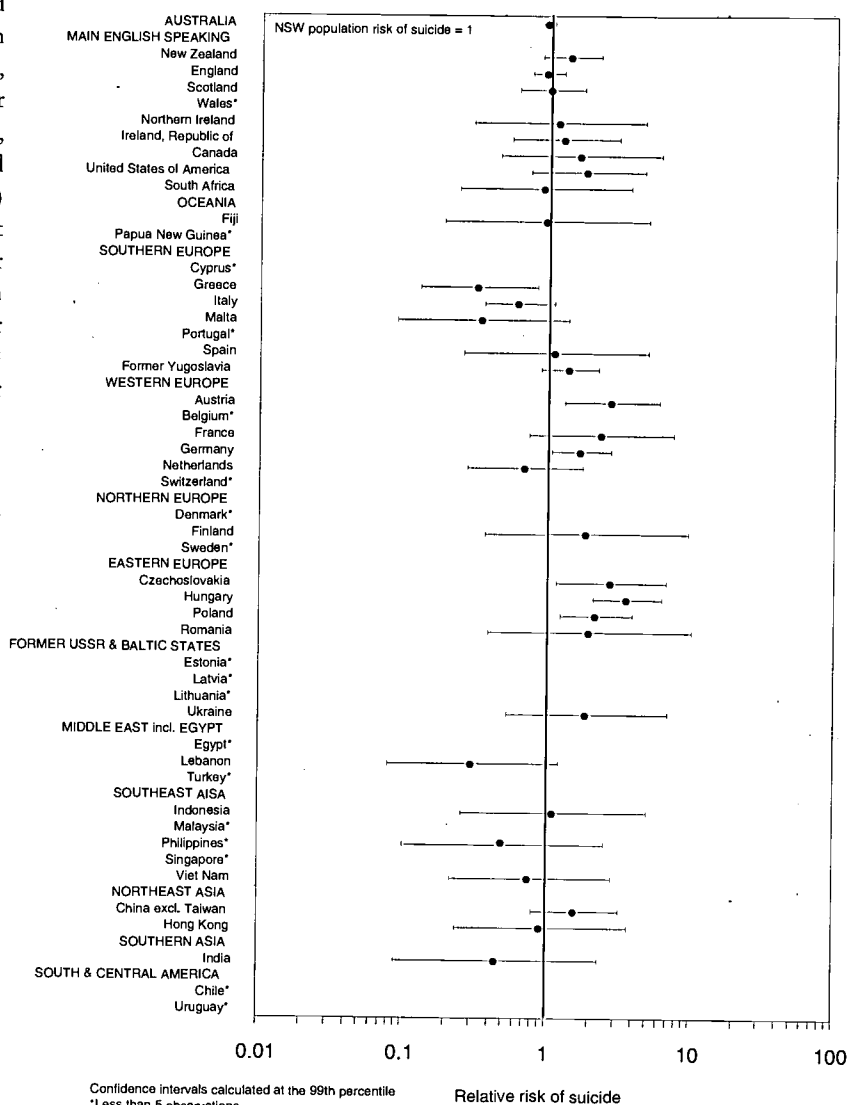
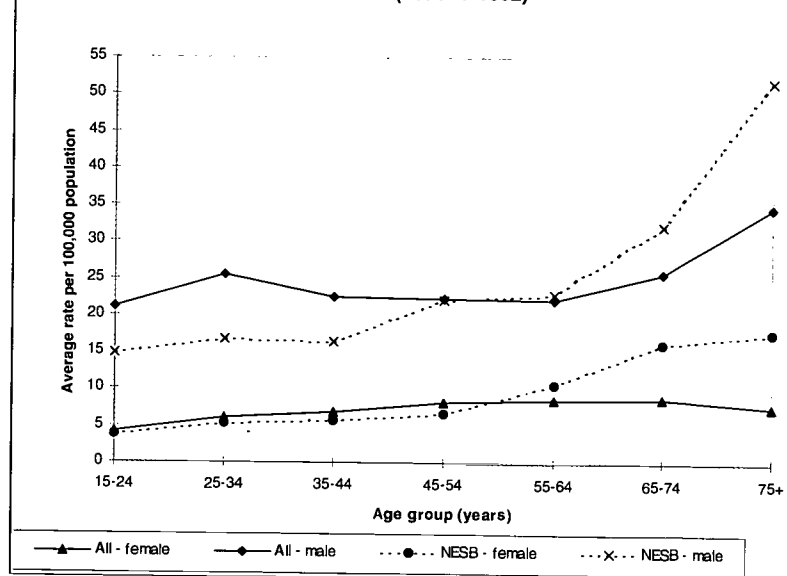


Figure 2. Age-Specific Rates of NESB Suicide by NSW Residents (1979 to 1992)



methods of suicide, such as firearms, and an increase in passive methods, such as self-poisoning and hanging (Hassan, 1995). Data on method of suicide by region of birth is reported by McDonald & Steel (1997) for the period 1979 to 1992. For the overall Australian community the main method of suicide for females was poisoning by solids and liquids. Together with poisoning by gases and vapours, poisoning accounted for 60.3% of all female suicides. The main variance from this was females from Southern Europe, Southeast and Northeast Asia where the most common method was hanging, accounting for 40-50% of all female suicides. Unlike most other regions jumping from a high place was a relatively common method for females from the Middle East/Egypt. For males, the most common method was the use of firearms and explosives accounting for 30.4% of all deaths. The main variance from this was with males from Southern and Eastern Europe and Northeast Asia where the main method was hanging.

Burvill et al (1982) explored the hypothesis that the longer immigrants lived in Australia the more similar their suicide methods would be to the Australian-born. The hypothesis was partially confirmed with males from Southern, Eastern, and Western Europe and females from Eastern Europe and Asia. Overall, the convergence of methods towards the Australian-born was greatest in immigrants who came from countries that were linguistically and culturally most similar to Australia.

McDonald & Steel (1997) report particularly high rates of suicide among elderly immigrants. Figure 2 shows the average age-specific rates of suicide for the total population and for immigrants of NESB for the period 1979 to 1992. For immigrants from non-English speaking countries the rates of suicide for those aged 75 years and over is up to five-fold greater than the rates for those aged 15-24 years. This contrasts with the same ratio for the Australian-born and immigrants from English-speaking countries which is 1.15 and 1.20 respectively.

This finding applies not just to those countries/regions of birth with high rates of suicide (for example, Eastern Europe) but also to countries/regions of birth with low rates, for example, Southern Europe, Middle East/Egypt and Northeast Asia. This pattern of relatively higher rates with the aged is not confined to immigrants, as suicide rates reported in the country of birth are also high. McDonald & Steel (1997) conclude that this increased risk of suicide amongst elderly NESB immigrants reflects the sociocultural factors that

TABLE 1

COMPARISON OF RANK ORDERS OF MEAN SUICIDE RATES PER 100,000 IN NSW (1979 TO 1992) AND IN THE COUNTRY OF BIRTH (COB)^{1,2}

| Country of Birth | Rate in NSW | Rank | Rate ³ in country of origin | Rank ⁴ | Ratio of rate in NSW to rate in COB |
|-----------------------------|-------------|------|--|-------------------|-------------------------------------|
| FEMALE | | | | | |
| Austria | 20.11 | 1 | 11.33 | 3 | 1.72 |
| Hungary | 16.16 | 2 | 22.35 | 1 | 0.72 |
| Czechoslovakia | 13.02 | 3 | 8.19 | 5 | 1.59 |
| Former Dem. Rep. of Germany | 10.71 | 4 | 13.14 | 2 | 0.82 |
| Poland | 10.19 | 5 | 4.74 | 9 | 2.15 |
| Former Yugoslavia | 9.19 | 6 | 10.70 | 4 | 0.86 |
| New Zealand | 6.91 | 7 | 6.03 | 7 | 1.15 |
| Scotland | 5.46 | 8 | 5.41 | 8 | 1.01 |
| England/Wales ⁵ | 5.18 | 9 | 4.00 | 10 | 1.29 |
| Greece | 4.47 | 10 | 1.82 | 12 | 2.46 |
| Netherlands | 3.5 | 11 | 7.87 | 6 | 0.44 |
| Italy | 3.49 | 12 | 3.66 | 11 | 0.95 |
| MALE | | | | | |
| Finland | 69.50 | 1 | 41.98 | 2 | 1.66 |
| Czechoslovakia | 40.01 | 2 | 27.32 | 5 | 1.46 |
| Hungary | 35.88 | 3 | 61.58 | 1 | 0.58 |
| Former Dem. Rep. of Germany | 33.60 | 4 | 32.95 | 4 | 1.02 |
| Poland | 33.55 | 5 | 22.94 | 7 | 1.46 |
| Canada | 24.24 | 6 | 21.52 | 9 | 1.13 |
| USA | 21.82 | 7 | 19.87 | 10 | 1.10 |
| Austria | 21.50 | 8 | 33.16 | 3 | 0.65 |
| New Zealand | 21.16 | 9 | 22.11 | 8 | 0.96 |
| Former Yugoslavia | 19.94 | 10 | 24.32 | 6 | 0.82 |
| England/Wales ⁵ | 18.56 | 11 | 10.81 | 15 | 1.72 |
| Scotland | 17.50 | 12 | 14.30 | 11 | 1.22 |
| Netherlands | 15.94 | 13 | 12.84 | 14 | 1.24 |
| Uruguay | 14.29 | 14 | 12.98 | 13 | 1.10 |
| Hong Kong | 13.48 | 15 | 13.06 | 12 | 1.03 |
| Malta | 12.50 | 16 | 4.50 | 18 | 2.78 |
| Italy | 12.42 | 17 | 10.40 | 16 | 1.20 |
| Greece | 9.86 | 18 | 5.45 | 17 | 1.81 |

¹Source: WHO World Statistics Annual

²All rates in country of origin are for 1987 except for Austria (1988), Former Dem. Rep. of Germany (1989), Greece (1986) and Malta (1988)

³Overseas age-standardised rates calculated using the NSW population as the reference population

⁴Kendall's rank correlation coefficient, $t = 0.606$, $p < 0.01$, $n = 12$ (females), $t = 0.699$, $p < 0.001$, $n = 18$ (males)

⁵England and Wales combined because data is aggregated in WHO published figures

Continued overleaf

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those immigrants bring with them rather than a differential impact of migration upon the aged. Relatively high rates of suicide among elderly NESB immigrants is also apparent in other Australian data (Burvill et al., 1973; Burvill et al., 1982; Whitlock, 1971).

Morrell and colleagues (1999) recently reported that male immigrants residing within rural NSW had twice the rate of suicide compared to male immigrants residing within metropolitan NSW. The authors also reported that the lower risk for suicide documented amongst Australian born females living within rural settings was not evident amongst migrant females living within rural settings. In summarising their findings the authors concluded that the increased rates of suicide widely reported in rural NSW is largely due to the high level of suicide amongst male immigrants in that setting. As the findings in this study were reported for all immigrants and not individual count of births, it is unclear if the observation is reflective of increased stresses facing immigrants residing in non-metropolitan settings or because immigrants from countries with high suicide rates settled in non-metropolitan NSW. Nevertheless, the findings indicate that immigrants within NSW rural settings are at particular risk for suicide.

CONCLUDING COMMENTS

The findings of research into suicide amongst immigrants to Australia can be summarised as follows. There is great diversity in the rates of suicide amongst the various ethnic groups. Immigrants from countries in Western, Northern and Eastern Europe, and the former USSR and the Baltic States display the highest levels of suicide in Australia. The rates of suicide amongst immigrant communities reflect the rates in the country of origin more than the rates in the country of resettlement.

However, the rates amongst some immigrant groups may be higher than the native rates especially amongst females. It has been hypothesised that the risk of suicide may be increased since migration often involves the disruption of social ties (Hassan, 1995) and increased stress (Kliwer & Ward, 1988), both of which are linked to increased rates of suicide. There are also clear differences in the main methods of suicide used by some immigrant groups. The similarity of rates and methods among immigrants to those in the country of origin suggests that the sociocultural factors that immigrants bring with them are important determinants of suicide within Australia.

High rates of suicide are particularly evident amongst elderly immigrants. The increased risk of suicide amongst the elderly applies not just to those countries/regions of birth with high rates of suicide (for example, Eastern Europe) but also to countries/regions of birth with low rates, for example, Southern Europe, Middle East/Egypt and Northeast Asia. Increased risk for suicide is also evident amongst immigrants living within rural NSW.

Except for the early work of Burvill and Whitlock, most suicide research in Australia has ignored issues to do with people of NESB. However, further investigation into suicide amongst people of NESB may offer an understanding of factors contributing to suicide in Australia. In particular the great diversity in suicide rates may provide an opportunity for identifying protective factors that account for the lower rates of suicide amongst some communities. Another implication from this research is that particular suicide prevention programs targeting at-risk groups within the broader community need to be evaluated for their relevancy for delivery in a culturally diverse society. As can be seen from the current review, at-risk groups within the broader community may

or may not also be at risk within NESB communities. In particular the investigations reviewed show that NESB aged are at increased risk as are immigrants from a range of Northern and Eastern European countries, and the former USSR and the Baltic states.

The programs of community education and awareness that are developed for the general Australian community may similarly not be broadly appropriate for many NESB groups. It is well documented that suicide is viewed very differently by different cultural groups (Farberow, 1975). While in some cultures it may be an acceptable way to avoid losing face and honour, in other cultures it may be viewed as a grave sin that will bring shame and disgrace on the family for many years (Farberow, 1975). Community education and awareness programs need to take into account these different values and attitudes towards suicide and be presented in ways that are culturally and linguistically appropriate. Because suicide is such a complex phenomena, a "complex-cause-complex-cure" approach is required (Diekstra, 1990). Effective suicide prevention models will involve multi faceted prevention strategies carefully designed to address the needs of the whole community, including minority groups as well as targeting those populations or sub-populations with high risk. ■

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maladjustment such as social skills deficits (Cerel, et al., 1999; Pfeffer et al., 1997)

Higher levels of anxiety, anger, and shame compared to children not bereaved by suicide (Cerel et al., 1999)

Higher risk of long-term adjustment problems in adulthood (Demi and Howell, 1991)

Long term impact on sense of worth and self-esteem due to the conscious abandonment by a parent by suicide (Dane, 1991)

It is common for social supports to be withdrawn following suicide (Appleby, 1993; Raphael, 1984; Ness and Pfeffer, 1990)

Death by Suicide can have a profound impact on mourning rituals and information about cause of death.

As part of the larger needs analysis for the children bereaved by suicide project four parents participated in two focus groups. The parents had between them 11 children who ranged in age from 2 to 19 at the time of death. All had experienced the death within the past three years. While adult caregivers are pivotal in providing emotional support to their grieving children, they also face the additional task of simultaneously experiencing and coping with their own intense grief.

Furthermore, Furman (1974) and Baker and Sedney, (1996) argue that children need appropriate emotional support to be able to mourn sufficiently. Appropriate professional support for parents would therefore appear to be an essential part of assisting parents to both identify and respond to their child's grief appropriately. The secrecy involved in suicide has prompted Goldman (1996) to stress that the most effective therapy for children bereaved by suicide involves both the parent and child. She states that "if adults are frozen in blocks of time by fear and secrecy, there is little or no permission for

children to grieve" (p. 27). It is particularly notable therefore, that Demi and Howell (1991) found that factors such as the family's openness to expressing grief, the degree of secrecy, and the availability of emotional and material support, to be important long-term predictors of well being in adults bereaved by suicide in childhood.

In summary parents we interviewed wanted:

Access to local professional and non-professional grief support as soon as possible following the suicide – even if they did not need to access it immediately.

Written information about suicide and grief.

Referral and service information from immediate contacts such as Police, funeral directors and school staff (The Principal, teachers, and school counsellor).

Support from other parents – especially information about how to tell their children about suicide.

Children, like adults, grieve and mourn when they experience loss, but suicide generally has the potential to complicate the adaptation to loss as noted above. Children, however, are experiencing grief within the cognitive and emotional constraints of childhood. This developmental context influences not only the child's concept of death but also the way they mourn. Masur (1996) suggests that to begin to grieve, children must know that someone has died and that they must accept and emotionally acknowledge the reality of the loss. Therefore to truly begin their mourning children bereaved by suicide need to have some understanding of how the death occurred. Some research suggests only 50% of children are told that the death was suicide (Shepherd and Barraclough, 1974), with younger children usually at higher risk of not being told (Fraser, 1994, Shepherd and Barraclough, 1974). Children, like adults, cannot grieve the loss of their loved

Continued overleaf

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one fully until they have factual information about how the death occurred.

As part of the needs analysis we spoke to four children aged 7 to 13. Three had experienced the death of their father and 1 the death of a teenage brother. The children expressed a number of strong ideas about their loss and what support was most helpful to them.

The following is a summary of our interviews with children:

Children want adults to be honest about the cause of death.

"come straight out and tell them ... cause I didn't really like it being told at different times. I'd rather just accept it the way it was"

Children want adults to include them in rituals, provide plenty of reassurance and explanations about what is happening – that is to explain the funeral, the viewing, ask children what they understand about the word suicide.

"...well I think its important that every child should be able to see the coffin that their father was put in before they are put in the fire and cremated.... So that they can open the lid and see them for the last time"

Children want parents to use clear language when describing suicide

"... instead of saying they committed suicide you could say he killed himself... young people they wont quite understand what you are talking about"

Children wanted lots of reassurance - they didn't do anything to cause the death, that things will get better, that its ok to cry, and that everyone still loves them.

Children expressed great insight into the grief that they were experiencing and if given the opportunity wanted to talk about their grief

... at first I didn't believe it... and for about the first year I thought that he was still alive that he had just gone somewhere

but he hadn't contacted me. I knew what it meant and all but I didn't want to believe it. It was hard to believe that he had done it...

Children were worried that people were going to forget the person that died and wanted to actively make and keep memories.

... after my dad died my mum bought me a book to write down all the good memories in there ... so keep all the happy things in it and it will get you through.

The purpose of this article was to provide a brief overview of some of the important issues for parents and children bereaved by suicide. The project is currently implementing a number of strategies that have developed as a direct response to the needs analysis. A booklet, aimed at supporting young children titled 'Supporting Children After Suicide: Information for parents and other caregivers', has been drafted and reviewed by focus group participants and is soon to be printed. Workshops and other training sessions for health professionals have also been developed and, conducted in South Western Sydney. ■

If you would like more information about the project or would like to attend the one-day workshop please contact Kerrie Noonan.

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Events Calendar

July

15-16 Our Lives Our Choices
Australasian Consumer Run Mental Health Conference
Adelaide, South Australia
Tel: 08 8373 2063

27-28 Bridging Our Worlds
VICSERV 2000 Conference
Caulfield Racecourse, Melbourne
email: conf@vicserv.org.au

August

**2-3 Health Outcomes for the Nation:
Best Bets and Best Buys**
6th Annual International Health Outcomes Conference 2000
Rydges Lakeside, Canberra
Australian Health Outcomes Collaboration
Tel: 02 6205 0869
Email: jansan@atrax.net.au

**28-31 Creativity & Development:
Services for the Future**
10th Annual TheMHS Conference
Adelaide Convention Centre, South Australia
Tel: 02 9926 6057

Sept.

5 Physical Activity and Fitness in Young People
Department of Adolescent Medicine
New Children's Hospital
Westmead Sydney
Tel: 02 9845 3338

11-14 Global Challenges...Local Solutions
3rd International Respite Care Conference for People with Disabilities
Masonic Centre, Sydney
Email: interchangensw@S054.aone.net.au

October

**4-6 Transcultural Nursing:
Leading into the new millenium**
Royal College of Nursing Australia
Marriot Resort, Surfers Paradise, Gold Coast
Tel: 02 6282 5633
Email: conf@rcna.org.au

November

17-18 Promoting Multicultural Health & Well-being
First Forum of the SA Transcultural Mental Health Network
Adelaide Congress Centre
Adelaide
Tel: 08 8200 3900

21 Drugs and Other Issues
Department of Adolescent Medicine,
New Children's Hospital,
Westmead Sydney
Tel: 02 9845 3338

2001

March

4-7 Good Health - Good Country
6th National Rural Health Conference
National Convention Centre Darling Harbour
Tel: 02 6285 4660
Fax: 02 6285 4670
Email: conference@ruralhealth.org.au

May

**28-30 Diversity in Health:
Sharing Global Perspectives:**
2nd ATMHN Conference
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Commonwealth

Department of Health & Aged Care,
Mental Health Branch (02) 6289 7722

Community / Consumer / Carer Associations

Australian Mental Health Consumers Network (07) 3394 4852
Carers Association of Australia Inc (02) 6288 4877
Federation of Ethnic Communities
Councils of Australia Inc. (02) 6282 5755
Mental Health Council of Australia Inc. (02) 6285 3100
National Ethnic Disability Alliance (02) 6290 2061

New South Wales

Mental Health Branch, NSW Department of Health (02) 9391 9299
NSW Transcultural Mental Health Centre (02) 9840 3800

Northern Territory

Mental Health, Aged & Disability Services,
Territory Health Services (08) 8999 2916

Queensland

Mental Health Unit, Queensland Health (07) 3234 0674
QLD Transcultural Mental Health Centre (07) 3240 2833

South Australia

Mental Health Unit,
SA Department of Human Services (08) 8226 6275
SA Transcultural Mental Health Network (08) 8222 5141

Tasmania

Mental Health Program, Department
of Health & Human Services (03) 6233 4750

Victoria

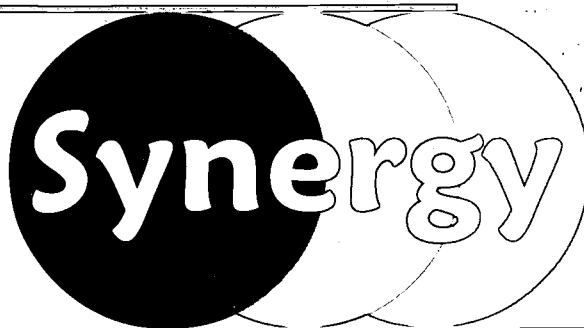
Aged, Community & Mental Health,
Department of Human Services (03) 9616 8123
Victorian Transcultural Psychiatry Unit (03) 9417 4300

Western Australia

Mental Health Division,
Health Department of Western Australia (08) 9222 4099
WA Transcultural Psychiatry Program (08) 9224 1760

*The Australian Transcultural Mental Health Network is an
initiative supported by the National Mental Health Strategy
and funded by the Commonwealth Department of Health and
Aged Care.*





PRIMARY CARE

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Spring 2000

DIVERSITY IN HEALTH: SHARING GLOBAL PERSPECTIVES

A landmark conference on multicultural health and well-being

SYDNEY 28-30 MAY 2001

CONFIRMED SPEAKERS

www.tmhc.nsw.gov.au/diversity.htm



DR TIMOTHY EVANS is Team Director of the Health Equity program of the Rockefeller Foundation, USA. His most previous position was as Assistant Professor of Population and International Health at the Harvard School of Public Health. His major research interests are measurement of health status in developing countries and equity in health.



DR M PARAMESHVARA DEVA is Professor and Head of the Department of Psychiatry, Perak College of Medicine, Malaysia. He has served as acting Regional Adviser in Health Promotion and Mental Health at the Western Pacific Regional Office of WHO. He has been active in training service providers and volunteers within many countries and cultures in the Asia Pacific region.



DR ANTHONY J. MARSELLA is Professor of Psychology, University of Hawaii and Director of the WHO Psychiatric Research Center in Honolulu. Dr. Marsella is internationally recognised as a pioneer figure in the study of culture and psychopathology who has challenged the ethnocentrism and racial biases of many assumptions, theories, and practices in psychology and psychiatry.



DR DIEGO DE LEO is Professor of Psychopathology and Suicidology at Griffith University, Queensland where he presently directs the Australian Institute of Suicide Research and Prevention. In 1998 he was appointed Director of the first WHO Collaborating Centre for Suicide Prevention. He acts as an advisor within their Global Network for Suicide Prevention and Research.



KALIOPE PAXINOS has been the carer of her son who has schizophrenia for the past 15 years. Kaliope worked at the Schizophrenia Fellowship supporting, training and educating carers for 5 years. Inevitably, because of her Greek background, Kaliope has worked with many families of various cultural backgrounds.



ROSEMARY WANGANEEN has spent many years healing the losses and unresolved grief relating to Stolen Generation issues. Rosemary has worked on the Committee to Defend Black Rights and the Royal Commission into Aboriginal Deaths in Custody. Rosemary will describe a culturally appropriate approach to holistic healing.



DR JOHN YU is Chancellor of the University of New South Wales. Former Australian of the Year and an internationally renowned Paediatrician, Dr Yu was Chief Executive of the Children's Hospital at Camperdown and then Westmead for 19 Years.

Registration Brochure in the next edition of Synergy

YOUTH ISSUES

Centre for Multicultural Youth Issues

A multilingual publication and website was recently launched by the Victorian Minister for Youth Affairs, Justin Madden, as part of the Austcare Refugee Week 2000. 'Landing on Your Feet! Important Legal Information for Newly Arrived Young People in Victoria' is the culmination of a project partnership between the CMYI, Victoria Legal Aid Federation of Community Legal Centres, the Equal Opportunity Commission of Victoria and the Victoria Law Foundation. The publication is available in several languages and has been funded with a grant from the Victoria Law Foundation. For further info please contact:
Carol Ransley
Centre for Multicultural Youth Issues
Tel: 03 9349 3466
www.cmyi.net/landing

Prescribed Drugs 'Risk to Children'

Parental pressure and inadequate health services have led to a growing number of doctors prescribing potentially dangerous psychotropic drugs for children under five, mental health experts have warned.

The latest Medical Journal of Australia says that in the past decade, the number of pre-school children treated with stimulants in NSW has risen 12-fold. From 1990 to 1999 nearly 6 000 children under six, who were diagnosed with attention deficit disorder, were treated with a psychotropic drug.

Child and adolescent mental health academics, Professor Joseph Rey, Professor Philip Hazell and Gary Walter, express their concerns in the journal's editorial and call for greater research into the effects of anti-depressants and antipsychotics on children.

The report says physicians assume that psychotropic drugs will be safe and effective for the young. "There is no evidence about the effect of these drugs on children aged under four years," Professor Rey says.

Sydney Morning Herald 21/8/00

More partnerships opt to cross cultural border

The Australian Bureau of Statistics reported recently that 52 per cent of the marriages registered in 1998 were between "people from different birthplace groups" - compared with 39 per cent in 1974.

DepressioNet.com.au Launched

DepressioNet.com.au is a one-stop resource for the information, help and support needs of Australians who suffer from depression and their support networks. In addition to information on accessing help that exists around Australia the website has a message board and chat room where visitors can communicate with each other or ask questions. The atmosphere in both the message board and the chat room is very much one of mutual support and encouragement. DepressioNet.com.au has recently been selected as a semi-finalist in the Australian Financial Review's 'Australian Internet Industry Awards 2000'.

www.depressioNet.com.au

Voice Key to Suicide Intention, Study Finds

The voices of people who have decided to commit suicide are higher pitched than those who are merely depressed, a United States study from Vanderbilt University, Tennessee has found.

Intending suicides in the study also used a narrower range of frequencies when pronouncing vowels.

The researchers said the changes appeared to be caused by "stress-induced physiological changes" - changes in muscle tone and the moisture and elasticity of the vocal cords.

Electronics engineer Dr Mitchell Wilkes said they were now investigating whether their findings could be developed into an early warning system to alert mental health workers which patients were seriously suicidal.

But Australian psychiatrists said even if such a development was possible, it was unlikely to be useful with individual cases of severe depression or mania leading to suicide.

"You might have hundreds of people whose voices sounded odd....The dilemma is that none of the predictors of suicide have any clinical relevance with individual people," said Professor Bob Goldney, for the Adelaide Clinic.

Sydney Morning Herald 18/8/00

Travelling the World Over Eight Evenings: A Cross-Cultural Mental Health Training Program for General Practitioners

Chhavi Pal, Bernadette Wright, Sam Febbo, Rosanna Rooney, Geoff Riley

The general practice is conventionally perceived as the more popularly used primary care facility. Community health centres and hospital-based primary care clinics are also models of primary care. However, it is the general practice upon which the following article will focus because, in many health care systems, it is the general practitioner (GP) who acts as 'gatekeepers' for a gamut of subsequent specialist medical care including specialist psychiatric care (Jackson-Triche et al, 2000).

Due to a less stigmatizing effect associated with consultations with general practitioners, people from culturally and linguistically diverse (CALD) backgrounds consider general practitioners as the preferable, (and sometimes, only), service provider for mental health care. For CALD community members, their choice of GP may be limited to general practitioners who come from the same ethnic background or who speak the same language (Mihalopoulos et al, 1999; Stuart et al, 1996; Pharoah, 1995). That priority should be placed on cross-cultural awareness training for general practitioners is becoming more imperative.

This article will describe an innovative cross-cultural training program for general practitioners which is currently in progress at the time of writing.

THE STATE OF PRIMARY CARE SERVICE DELIVERY FROM THE GENERAL PRACTICE

The majority of mental health problems are seen in the general practice (O'Dell et al, 1995; Al-Faris et al, 1997; Vazquez-Barquero et al, 1997). However, of all people presenting to their GPs with mental health problems, only 50% of such presentations are recognized (Goldberg & Huxley, 1992).

A comprehensive review by Mihalopoulos and colleagues cited the result of a survey conducted by the Royal Australian College of General Practice (RACGP, 1995) suggesting that up to 90% of mental illness and mental health problems may be treated by general practitioners. A landmark Australian study by Bridges-Webb et al (1991; cited by Mihalopoulos et al, 1999) found that 6% of consultations with GPs were caused by 'psychological problems' though this figure does not take into account undetected mental health problems. Evidence further suggests that positive diagnoses of mental illness are made very infrequently by GPs, and this occurs only when morbidity is apparent (Al-Faris et al, 1997).

Research by the World Health Organization (WHO, 1992) indicated that approximately 24% of primary care patients worldwide suffer from mental disorders recognized by ICD-10; and a recent review by Loerch et al (2000) cited studies from the '70s and '80s placing prevalence rates ranging from 16% - 55%. However, Goldberg & Lecrubier (1995; cited by Loerch et al 2000) demonstrated that there is a low to moderate concordance rate between physician's definition of psychological disorder and that defined by ICD-10. As borne out by research, cross-cultural validation of the subcategories of common mental disorders (eg. those disorders manifesting with symptoms of depression and anxiety) is questionable – particularly when there is high co-morbidity of these disorders (Patel, 1996).

Continued Overleaf

Synergy Spring 2000

PATHWAYS TO MENTAL HEALTH SERVICES

The WHO (1992) study also found that other than in Europe and North America, few patients with mental disorders present to their GP with psychological symptoms. Because the majority of patients tend to present their GPs with physical symptoms only (Craig & Boardman, 1997), a large proportion of psychiatric disorders are not detected by GPs. However, the high presentation of somatic symptoms to GPs (by people suffering from a psychiatric disorder) may be partly ascribed to the patient's erroneous perception of the role of the doctor. That is, the general practitioner is only deemed appropriate for consultation about physical illness rather than about psychological problems (Goldberg & Huxley, 1980).

The literature echoes persistent findings confirming that the pathway to seeking help for mental health problems begins with the general practitioner (Mihalopoulos et al, 1999; Patel, 1999). A study in the United Kingdom found that at least two-thirds of those arriving at psychiatric services had initially presented to their GP and, subsequently, given an onward referral to the specialist mental health service. Only a very small proportion of people reach specialist services via alternative routes (Goldberg & Huxley, 1980).

The model of pathways to care developed by Goldberg & Huxley specifies that a 'filter' process is initiated upon consulting with the general practitioner. The 'sick role' assumed by the patient, which initially led to the GP consultation, requires 'validation' by the GP through attribution of meaning to the symptoms experienced by the patient. Progression to secondary level services (eg. specialist mental health services) or to receiving appropriate treatment, is dependent on the GP's ability to detect the psychiatric nature of the disorder and his or her conclusion that it warrants an onward referral.

However, where the consultation is 'cross-cultural' in nature factors will influence the general practitioner's recognition of psychological and psychiatric problems. Recognition will vary according to the patient's ethnicity, cultural influences on clinical presentation, as well as the influence on which the patient's explanatory model of his condition may have on the doctor-patient interaction (Kleinman, 1995; Carillo et al, 1999). These variables may lead the general practitioner to 'miss opportunities' for making timely diagnoses of mental illness (Bahl, 1999).

ISSUES IN CROSS-CULTURAL CONSULTATION

A study of cross-cultural consultations in GP practices in the United Kingdom found results that were consistent with previous findings suggesting that Asian and Black patients have psychological problems identified less frequently than their White counterparts; and, that the tendency for misdiagnoses was also greater (O'Dell et al, 1997).

Bhugra et al (1999) suggest that if mental health is not conceived in mental health terms, as is the case in many cultures, then the only means by which mental health problems would be verbally communicated is through description of physical symptoms for which the culture's vocabulary can readily accommodate. For example, the Chinese belief that health, including mental health, is achieved through a system of balance (eg. yin and yang) would have the implication that a state of imbalance might only be addressed at the physical level. Leff (1999) asserts that even if the given language contains phrase equivalents for describing psychological or psychiatric symptomatology, there is no certainty that it will bear a direct relationship to the disorder in question, and, moreover, it may have a 'strong somatic reference'. Furthermore, the point is made by Leff that a culture's attribution of symptoms to 'abnormal

behaviour(s)' or mental illness-related concepts (as they may be understood by Western diagnostic and classification systems), is dependent on the coping mechanisms accepted and implemented by the given culture, for dealing with the related symptoms and conditions.

The strong attachment of stigma to mental illness in various cultures is widely acknowledged as a significant barrier to seeking timely and appropriate assistance for mental health problems. Stigma is also one of the causes for somatization of mental illness during GP consultations (Bakshi et al 1999). Indeed, somatization of mental illness is particularly prevalent in non-Western societies (Kirmayer, 1984). In the light of challenging evidence, however, Gureje et al (1997) point out that somatization is not solely confined to patient populations in developing countries. Their study found that somatization is neither more, nor less, common in developing countries compared with developed countries; and, the notion of somatization being a characteristic within certain cultures found only 'modest' support.

It is well acknowledged that illness symptomatology, illness behaviour and illness presentation, deemed 'normative' in one culture, may lack meaning or have different implications in another culture (Lloyd & St Louis, 1999). Sociocultural factors influence the degree of differences in expectations, concerns, meanings and values between patients and their general practitioners (Carillo et al, 1999); and it can also lead to communication barriers (Takeuchi et al, 1995). In turn, effective communication between doctor and patient is fundamental to facilitating patient satisfaction and compliance with medical recommendations (Novack, 1995). The patient's sociocultural background and how this may affect their health beliefs, are crucial to ensuring a mutually effective and successful patient-doctor interaction (Kleinman et al, 1978).

NATIONAL FORUM OF SERVICES FOR SURVIVORS OF TORTURE AND TRAUMA JOINS ATMHN

The ATMHN Advisory Group was pleased to welcome Mr Jorge Aroche, representing the National Forum of Services for Survivors of Torture and Trauma to its meeting in Sydney in August. This is the first time that Torture and Trauma Services have been represented on the ATMHN Advisory Group, and we look forward to a constructive and mutually beneficial relationship.

CONFERENCES

In August the ATMHN attended TheMHS 2000 Conference in Adelaide where a range of papers were presented highlighting the work of transcultural services from around Australia. The ATMHN stall was again popular with delegates. Thanks to Mark Loughead of SA NESBWEB and Myong de Conceicao, Jan Kang, Anna Piperides Lee and John Spiteri NSW TMHC for their help.



'DIVERSITY IN HEALTH'

Planning for "Diversity in Health" is well under way. Interest in the Conference is booming, with people from all around Australia involved with developing the program. We have been receiving abstracts Australia wide and overseas, including five from Africa. The National Steering Committee has confirmed speakers from the United States, Asia and the Pacific and around Australia. For updates on keynote speaker and the conference program check the "Diversity in Health" web site at www.tmhc.nsw.gov.au/diversity.

FAREWELLS

The Advisory Group farewelled Professor Rob Barrett and Ms Vicki Katsifis and welcomed new representatives from South Australia, Western Australia and the ACT. Since the meeting we have also learned of new challenges ahead for Ivan Frkovic and Nada Martinek from Queensland. Good luck and thank you for your contributions to the ATMHN.

OLYMPICS

The ATMHN Management Unit has now returned to normal operations following some disruption during the Sydney 2000 Olympics. To anyone who has contacted the Management Unit during this time, thank you for your cooperation and patience. The 2000 Olympics were a very exciting time for all Australians, not just Sydneysiders, and highlighted the multiculturalism of our country. We wish the Paralympians all the best.

ADELAIDE FORUM

Synergy contains information on the SA Transcultural Mental Health Forum "Promoting Multicultural Health and Well-being" to be held at the Adelaide Congress Centre on November 17-18, 2000. The next ATMHN Advisory Group Meeting, will be held in conjunction with this forum on November 16, 2000.

WEBSITES ON PRIMARY CARE

PRIMARY MENTAL HEALTH CARE – AUSTRALIAN RESOURCE CENTRE

<http://som.flinders.edu.au/fusa/parc>

Includes a database which evaluates primary mental health care resources, a listing of 170 web links to primary mental health care resources and an email discussion list.

NATIONAL INFORMATION SERVICE OF THE GENERAL PRACTICE EVALUATION PROGRAM

<http://som.flinders.edu.au/fusa/gpnis>

The NIS was established to support the Strategic Evaluation Group (SEG) in their task of overseeing the activities of the General Practice Evaluation Program (GPEP)

THE AUSTRALIAN INSTITUTE FOR PRIMARY CARE

<http://aipc.latrobe.edu.au/>

The AIPC promotes quality improvement and best practice in all areas of primary health care.

PRIMARY CARE PARTNERSHIPS

www.dhs.vic.gov.au/acmh/ph/pcp/index.htm

Within the Department of Human Services, Victorian State Government website.

CENTRE FOR PRIMARY HEALTH CARE

<http://www.spmed.uq.edu.au/cphc/>

Information on the Centre for Primary Health Care and issues relevant to primary health in Australia and around the World.

Moments of no consequence
Seem to make a lot of sense;
Like the gentle pitter patter
Of the things that do not matter
As I sit alone and stare;
Neither here and neither there.



"Moments of No Consequence" by Michael Leunig from *Goatperson & Other Tales*, published by Penguin Books

In Their Own Words

Angela Piscitelli

During 1998, the South West Metropolitan Mental Health Services Planning Group and the Association for Services to Torture and Trauma Survivors undertook a mental health needs assessment of culturally and linguistically diverse communities in the south west metropolitan region of Perth, Western Australia. The resulting report, *In Their Own Words*, is summarised here.

INTRODUCTION

Despite constant reiteration at policy level of the importance of not only access but equity of access to mainstream public mental health services, there remain many people who clearly do not gain services on an equitable basis. Among these are people of non-mainstream or non-majority cultures, particularly those of first generation non-English speaking background.

These people bring to Australia a highly diverse range of beliefs, attitudes and practices related to every aspect of life, which often differ markedly from those prevalent in Australia's majority cultures. Among these are beliefs and attitudes related to mental health and illness, and opinions about what constitutes an appropriate model of treatment.

In addition, migration undoubtedly has a significant impact on psychological wellbeing. While migration per se is not a determinant of mental ill health, circumstances surrounding an individual migration experience can increase the likelihood of any given individual experiencing impaired mental functioning at some stage. Studies over the past two decades underscore the extremely high rates of psychiatric sequelae and the prevalence of post-traumatic stress disorder (PTSD) among refugees and particularly survivors of torture and trauma.

The Australian health system has largely failed to adequately understand and respond to these issues, consistently exhibiting major deficiencies in the identification and treatment of mental illness among Australians of non-majority cultures. Specifically, consumers of mental health services culturally and linguistically diverse backgrounds are under-represented in preventative services yet over-represented in crisis services. This not only exacerbates the personal suffering experienced by these people and their families, but also contributes to substantially increased direct and indirect costs to the community.

METHODOLOGY

Five ethnic groups were chosen to participate in this research. Collectively, these groups are representative of the diversity among migrant communities in terms of differences in the reasons for migration and variations in the length of settlement. The communities chosen were:

AFGHAN

The Afghan community is relatively small, with many of its members very recently arrived. As a whole, it seems that Afghan migrants are experiencing extreme difficulty in settling. They make up a large proportion of those families identified by Family and Children's Services as 'in extreme hardship' in the south west metropolitan area, and frequently access a range of social and mental health services.

Continued Overleaf

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POLISH

As a large group in the south west metropolitan area who arrived up to twenty years ago as refugees, they were felt to represent a good example of a settled refugee community. They had access to very little in the way of settlement services in the years following their arrival. As such, their situation is illustrative of the results which can be expected if settlement services are not provided for migrants at an early stage. Consultation with service providers identified people of Polish backgrounds as consistently accessing a range of mental health services, with problems now being perpetuated into the second generation.

PORTUGUESE-SPEAKING

The Portuguese community is very large in Western Australia generally and in the south west metropolitan area specifically. Again, consultation with service providers identified that both first and second generation community members were frequently accessing a range of mental health services. They represent a settled migrant community, with many having arrived between fifteen and thirty years ago. However this group also includes Portuguese-speaking Mozambicans who arrived recently as refugees.

WOMEN FROM THE PHILIPPINES AND THAILAND

Women from the Philippines and Thailand who had married Australian-born husbands were consistently presenting at crisis services due to emotional and physical violence in the home. They represent a voluntary migrant group, although it is acknowledged that tragic circumstances may have preceded their migration.

EAST TIMORESE

The East Timorese community in Western Australia is of a similar size to that of the Afghan community, and also fled extremely traumatic

situations. They were virtually absent in the statistics of any mental health service providers. It was felt important to attempt to ascertain the reasons behind this. They represent a medium-term refugee community.

For each of these groups, a bi-lingual / bi-cultural researcher was appointed. During March 1998, a total of 37 people from these backgrounds who had either experienced some form of mental illness or had been caring for someone with a mental illness were questioned in their first languages about the services they received and those they would have liked to have received.

SUMMARY OF RESULTS

GENERAL PRACTITIONERS

The first point of contact for the majority of clients was their General Practitioner (GP), and for many of them, this person remains their main source of treatment and ongoing support. Despite this, it was clear that GPs were not referring clients to appropriate services where these were available. Indeed, it seems that a full range of support options are generally not explored, with many service providers contacted for possible client referrals reporting no culturally and linguistically diverse clients. One interviewer felt that:

Services are only initially contacted in response to a crisis event, and only generally used for that event or on subsequent similar events. There doesn't appear to be a very holistic referral process or any links being made between the family and people who will be able to support them in either a professional or social way.

Many patients reported being given medication by their GPs when they had repeatedly requested another treatment, for example counselling or therapy. Some felt that GPs really did not have the time to explore a range of options with their patients, but only used a limited set of services with which they were familiar.

CULTURAL SENSITIVITY

Many people who had accessed services perceived them to be culturally insensitive. They felt that their language and cultural needs were not acknowledged, nor taken into consideration when offering treatment or services. East Timorese people felt that social workers empowered children, which conflicts with Timorese cultural mores. Afghan people felt that their cultural construction of male-female relationships was similarly not valued nor taken into account by services. To both of these groups, this general lack of cultural understanding was at least as significant a barrier to using the service as the language problem. GPs were frequently reported as being unsympathetic to migrant clients, telling distressed patients to 'pull themselves together' or in one case to 'go back where you came from' if the person was not happy in Australia.

Several of the interviewees identified that such experiences within the mental health system were actually a factor in the deterioration of their mental wellbeing. One of the interviewees described the following situation that occurred at a major Perth public hospital:

One of the nurses who came up to our ward made a joke to one of the patients in the room, which made me really angry. The nurse said, "Why are you crying? Are you missing your husband's sausage?"

Another interviewee said of the same hospital:

I had my second attack of depression there. My psychologist was no help. She caused me more damage ... [she] was culturally blind. She applied Australian criteria to me. She thought we were childish in Poland, living with three generations under one roof. I was told, "you don't love your husband so you should leave him, give him the freedom to find someone else".

TASMANIA

My name is Gloria Lee and I am pleased to be the Project Worker in developing the transcultural mental health capacity in Tasmania.

The Transcultural Mental Health Project commenced at the end of July. The project marks a further step in recognising the needs of people from culturally and linguistically diverse background for mental health services, even in a small state like Tasmania. Because of the small and dispersed migrant population in Tasmania, we do not have as many resources and specialised services as the bigger states. My first challenge is to research the needs and the possible ways to develop the transcultural mental health service in Tasmania.

To determine this, I am working on the needs assessment in the first few weeks of the project. I will focus on information collection and listening to mental health service providers, ethnic community leaders and members, and consumers, about any mental health issues and problems. I am particularly concerned with issues of people from CALD with mental health problems accessing services. Hopefully, the information gathered can help me to develop comprehensive recommendations for future transcultural mental health work in Tasmania.

Email: mrcltn4@tassie.net.au or tel: 03 6331 2300.

ACT

The ACT is about to commence, with great enthusiasm, the project for which it received funding earlier this year.

The ACT is less developed in terms of the organisation of transcultural mental health organisations, although there are some useful existing networks, into which our newly employed Project Officer, Ms Salva Crusca, will be able to tap. The project will aim to improve mental health outcomes for people from culturally and linguistically diverse backgrounds through the provision of community and service provider education. The Project Officer will work closely with the NSW Transcultural Mental Health Centre, and will engage key members of culturally and linguistically diverse communities to ensure that as much of the target population as possible is reached.

Ms Crusca will be supervised by Mr Paul Wyles, who is the manager of the Community Education Unit within ACT Mental Health Services. Ms Crusca's physical placement will ensure that she is in constant contact with a significant group of primary mental health workers and their clients.

ATMHN FUNDED PROJECTS

WESTERN AUSTRALIA

PROMOTING CULTURAL AWARENESS IN THE MANAGEMENT OF MENTAL ILLNESS: A RESOURCE KIT FOR PRACTITIONERS

Contracts have now been signed and this project is now well under way with the establishment of a dynamic Reference Group and the recruitment of a Project Officer.

In undertaking research in the transcultural mental health field, the Reference Group is wary about duplication and embarking on a project that may potentially be a small 'variation' of what has been previously conducted, only to arrive at an outcome bearing very little, or no difference, to that produced by previous work. Therefore, we aim to utilize previous research and take the valid findings and valuable recommendations one step further to produce an outcome that is innovative, and one which is clinically useful, applicable, and relevant.

We have commenced a comprehensive literature search to review studies that have examined clinician-client communication that is facilitated or measured through the use of tools, in the area of mental health. A preliminary examination of publications held in electronic databases suggests literature within this area is sparse, particularly where it pertains to dynamics, at the micro level, between clinician and client in relation to cultural knowledge and culturally sensitive clinical practice. Contact has also been initiated, at a national and international level, with researchers who have expressed a keen interest in this project due to its clinical applicability, and whose work is of relevance to this project.

SOUTH AUSTRALIA

THE RECIPROCITY IN EDUCATION PROJECT: ENGAGING COMMUNITIES AND MAINSTREAM MENTAL HEALTH WORKERS

Nicholas Procter, Mohammed Amirghiasvand
Angela Eaton, Riya Engelhardt and Arthur Moutakis

Synergy readers will be aware that the *Reciprocity in Education Project* is a 12 month pilot activity aimed at developing a model of interactive learning between mainstream mental health services and three non-English speaking communities. The project brief is the result of work undertaken by NESBWEB: The South Australian Transcultural Mental Health Network.

In recent times the project team have undertaken consultations with members of the Italian, Persian and Cambodian communities on the topic of sadness and depression (broadly defined). Groups from each of the three NESB communities have been meeting in various locations across Adelaide including a primary school, a community centre and a community health service. To facilitate a 'homely feeling' the Italian group is meeting in the home of the Chief Executive Officer of the South Australian Italian Village, Ms Marcia Fisher while she is at work.

For simplicity, the project team and community groups have been working with the broader terms of "sadness, feeling sad, feeling down, feeling unhappy, emotional loss, and feeling tearful" when consulting community members about mental health issues, rather than being restricted to the term "Depression". After extensive work by the project team in the areas of developing trust, respect and effective working relations with community groups, participants from all three groups have begun explaining their ideas, experiences, beliefs, attitudes and understanding of these feelings and the metaphors used to describe them. A total of five compilation stories (two Persian, two Cambodian and one Italian) of these experiences have been developed by community participants.

The compilation stories have been used as a basis to develop an educational interaction between the three NESB communities and mainstream mental health services. This educational interaction is highly original in the way that it engages both community people and mental health workers as experts at a grass roots level.

The compilation stories have been presented to mainstream mental health workers at workshops involving staff from the three South Australian Universities. Workshops have also been held with

various community groups and local health workers. In addition to metropolitan settings, a workshop was held with rural and remote mental health workers as part of the *Innovations 2000* Seminar Program. Further workshops and forums are planned with mental health workers from regional teams.

A comprehensive education and training package for the Community Educators attached to each of the NESB groups is being developed as the project unfolds. The package centres upon learning directly from mental health workers about the way they interpret, analyse, and intervene upon mental health issues in clinical practice. Recent and up-coming topics include; Mental Health and Mental Illness; Clinical Features and Modes of Treatment for Depression; Networking with Mainstream Mental Health Workers; The Law and Mental Health; Forensic Mental Health; Evidenced Based Mental Health; Peer Support Mechanisms for People with Mental Illness; Child and Adolescent Mental Health: Issues for Children of People with Mental Health Problems.

For further information please contact
Dr Nicholas Procter
Tel: 08 8200 3900
Email: nicholas.procter@dhs.sa.gov.au

QUEENSLAND

MENTAL HEALTH SHARED CARE FOR ETHNIC COMMUNITIES – A LOCAL RESPONSE IN BRISBANE

Mental health shared care between mental health services and general practitioners is an increasingly popular model of care. Across Australia, shared care models are being established, some have been in operation for several years and evaluations have demonstrated that they are effective models of care.

For ethnic communities however, there is less information available about effective models of shared care. Mihalopolous et al identified the need for further piloting of different models of shared care and comprehensive evaluations of these models before any conclusions can be drawn about an optimum shared care model for ethnic communities.

This article is reporting on work in progress in Brisbane, which is currently piloting a shared care approach between the Brisbane Inner South Division of General Practice and key services working with people from non English speaking background with mental disorders. The project also has a strong evaluation focus and has engaged a health economist for advice and input into the evaluation design.

LOCAL PROFILE

The Brisbane Inner South Division of General Practice is located in the inner southern suburbs of Brisbane with many suburbs comprising more than twice the Brisbane average of NESB populations. Within the division's geographical boundaries are also located all of the Department of Immigration and Multicultural Affairs On Arrival Accommodation flats for newly arrived refugees.

In close proximity to the division are 3 key services for migrants and refugees with mental health issues: Qld Transcultural Mental Health Centre, Ethnic Mental Health Program and the Qld Program of Assistance to Survivors of Torture and Trauma. The region also includes 2 Queensland Health Adult Mental Health Services. As the geographical boundaries of the mental health services incorporate a neighbouring General Practice Division, the project is also including GPs from the Brisbane Southside Central Division of General Practice.

The division has previously been involved in the establishment of an early intervention model responding to the health needs of newly arrived refugees in its local region and building on this work the division is now seeking to establish a model of shared care between general practitioners and ethnic and mainstream mental health services for its local ethnic communities.

KEY PROJECT COMPONENTS SHARED CARE

The project is working with key stakeholders to establish and pilot a shared care model for people of non English speaking background exhibiting the early signs and symptoms of a mental disorder. Partners include general practitioners from the Brisbane Inner South and Southside Central Divisions of General Practice, Adult mental health services, the Ethnic mental health program, the Qld Transcultural Mental Health Centre, the Qld Program of Assistance to Survivors of Torture and Trauma and the Qld Divisions of General Practice Mental Health Support Strategy.

EVALUATION

The project will conduct a prospective evaluation to determine:

- The magnitude of the problem addressed by the intervention (literature review, prevalence data from GPs)
- Whether the intervention worked according to the specified objectives of the project (program effectiveness evaluation)
- An indication of the cost of management of depression/anxiety by a GP from the perspective of cost to the government (cost analysis)

ATMHN FUNDED PROJECTS

ISSUES TO CONSIDER WHEN DEVELOPING SHARED CARE ARRANGEMENTS

Shared care typically tends to focus on the development of systems and protocols to facilitate communication between the parties involved in shared care. In Australia, the majority of mental health shared care has been in the context of discharging stable patients from mental health services to the care of a general practitioner.

However, this project is working at the other end of the spectrum and seeking to increase GP skills and confidence in the recognition and identification of the early signs and symptoms of mental disorders in patients from non English speaking background.

Detection of mental disorders and mental health problems in General Practice has been studied worldwide and GPs have been widely criticised for poor recognition of mental disorders. It is generally accepted around 30 % of the general population meet the criteria for a mental disorder in any year. One third of that group will seek treatment and GPs see three quarters of this group. It has been suggested that people with mild and transient disorders will largely go untreated, people with chronic disorders are moderately served and only half of those with severe disorders will be treated.

Given the complexities surrounding identification and diagnosis of mental disorders in a Transcultural context the project is focusing on training and supporting GPs to identify and manage patients from NESB and a number of resources and arrangement have been offered to the GPs in the project to support and resource them in providing appropriate care to their patients.

The project has engaged representatives from the key agencies in a process of developing systems and mechanisms to enhance access to services, and improve communication and feedback for all parties involved in sharing the care.

ENGAGING GENERAL PRACTITIONERS

The project has recruited 15 interested GPs to participate in the piloting of this model. For evaluation purposes the GPs have been allocated to 2 groups so that comparisons can be made with GPs who receive training and support from the project and those who continue to provide standard care. GPs were recruited to the project in less than 2 weeks which indicates a strong interest and willingness in General Practice to participate in mental health shared care.

PROFILE OF PARTICIPATING GENERAL PRACTITIONERS

GPs who nominated an interest in participating are predominantly bilingual and have a particular interest in ethnic health. The majority have a patient load with over 50% of patients from a non English speaking background. Several have a patient load of over 90% from a non English speaking background.

OPPORTUNITIES

The project is able to capitalise on opportunities that are around for GPs to use new MBS items to claim for the development of patient care plans or coordinate or participate in case conferences. This has opened a window of opportunity for mental health services staff to actively engage GPs in the development of patient care plans and to clearly outline individual roles and responsibilities in the care of the patient and to involve GPs in case conferences.

ISSUES TO CONSIDER WHEN EVALUATING SHARED CARE

The project was asked to give consideration to economic issues when evaluating the project. It is clear that when conducting an economic evaluation two things need to occur: there must be an intervention and control group and the program must be conducted over a sufficient time period in order for outcomes to be measured.

In relation to this project neither are possible: it is not possible to conduct a random control trial (RCT) and compare the impact and outcomes of shared care to standard care or care for NESB patients to non NESB patients. Patient throughput in a demonstration project such as this is too low to draw any significant statistical conclusions and the pilot phase of only 10 months does not allow for sufficient time to measure outcomes.

A literature review of economic evaluations in mental health care revealed that relatively few full economic evaluations have been conducted in the mental health care field nationally and internationally. In regard to design, the literature recommends RCTs as the most scientifically rigorous method, however in mental health care randomisation is not always realistic or even possible.

A British study on evaluating innovative models of mental health care found that the selection of study designs posed several problems due to the difficulties involved in comparing innovative models to standard care available and highlighted the difficulties involved in conducting RCTs, the optimal study design. It suggested that many outcomes of interest may only be amenable to qualitative methods of investigation and a further challenge to assessing the comparative cost of different models of service delivery is therefore to integrate qualitative and quantitative outcomes assessments.

Given the above, the project is attempting to address some of these issues in its evaluation design:

The one group of interested GPs has been divided into 2 subgroups: one that received training and information on shared care earlier than the other group so that some element of comparison is possible.

Data collection tools have been developed in the form of GP checklists where GPs are recording a range of data at various time periods during the pilot phase. It is hoped that this data will provide some insight into the prevalence of depression and /or anxiety in people from non English speaking background, the range of shared care options utilised by GPs and the cost of services provided by GPs.

WHAT QUESTIONS WILL THE PROJECT ANSWER

The project will be able to provide information about the impact of the training provided to the GPs on detection in a Transcultural context, uptake of the shared care arrangements made available by the project and the quality of the shared care arrangements from the perspective of the key stakeholders involved. In addition, this project can be envisaged as a feasibility study to see if GPs are willing to collect the measurement data that provides a cost structure for the service provided by the GP. Based on the findings of this project, a model could be outlined for future evaluation and data collection of similar projects.

The project will develop a resource kit containing information about the lessons learned from the project in regard to setting up a shared care model of mental health care for people from non English speaking backgrounds and how to evaluate such a model. This will be available by June next year.

For further information please contact:

Rita Prasad-Ildes

Project coordinator

Brisbane Inner South Division of General Practice

Tel: 07 3392 2822

Email: rita@bisdiv.com.au

Race and childbirth

Women's personal accounts of pregnancy and childbirth are examined within the context of the immense diversity that exists within the South Asian communities in terms of socio-economic, cultural, religious and immigration history. While examining these personal accounts the author also focuses on the central role of older female relatives in the maintenance of traditional practices and their influence over pregnant women within extended families.

Savita Katbamna

Call number 362.1 KAT

Facing death

Facing death is a publication that brings together health professionals and distinguished authorities in the humanities to reflect on medical, cultural, and religious responses to death.

Edited by H Spiro et. al.

Call number 306.9 FAC

Ethics culture and psychiatry, international perspectives

This is much more than a book on ethics. Using a panel of distinguished experts, the editors have created a major contribution to understanding the impact of culture and history on the ethical practice of medicine around the world. It is an outstanding book on transcultural psychiatry.

Edited by Okasha et al.

Call Number 616.8921 ETH

Training know-how for cross-cultural and diversity trainers

This book provides an introduction to the mechanics of the training world. It has been designed so that it can be used in training of others workshops or used, equally successfully, by individual trainers who want to improve their understanding of cultural difference.

Call number 658.3 TRA

Teaching about culture, ethnicity & diversity

This is a book of easy-to-use classroom and training exercises that are intended for use in teaching about culture, ethnicity and diversity. A practical book for educators it is invaluable in the fields of clinical/ counselling psychology. Social work, cross-cultural psychology, and ethnic studies.

Edited by Theodore M. Singelis.

Call number 306.071 21 SIN

Honoring differences: cultural issues in the treatment of trauma and loss

This book deals with the treatment of trauma and loss while recognizing and understanding the cultural context in which the mental health professional provides assistance. Various cultures within the United States and several international communities are featured in the book. Each culturally specific chapter aims to help the caregiver.

Edited by Kathleen Nader, Nancy Dubrow and B. Hudnall Stamm.

Call number 6165.8521 NON

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RESOURCE PERSONS NETWORK

For those who wish to contact people who offer advice and specialised knowledge in areas that relate to Transcultural issues then visit the Resource Persons Network at:

http://www.atmhn.unimelb.edu.au/about/resources_people.html

WHAT'S NEW

The ATMHN web site's "What's new" section is all about keeping people informed about relevant transcultural mental health news and upcoming events happening in Australia. To have your news or events listed please email Lorraine Stokes at:

l.stokes@medicine.unimelb.edu.au.

TRANSLATED MATERIAL

A wide range of material translated into languages other than English can be found on the ATMHN website.

<http://www.atmhn.unimelb.edu.au/library/brochures/brochures.html>

Daylight Escape

Daylight is leaving the land
With pain and looking back,
they leave their homes, never to return.

Daylight escapes.

With pain, the pain from loving,
they escape through the jungle.

With pain, the sadness of death overhanging,
the ground on fire,

daylight and life leave through the mountains.

The intersecting, everchanging lines of the journey –
to leave for life, for freedom.

Constant turning around, looking back,
with the jungle on fire,

the smoke from burning bodies,
with revenge on their minds,

They leave their garden to the evil,
leave their home to the enemy.

With pain, daylight is leaving their loved ones
to the monster.

Far away in the land of no one,
where they are no one.

They leave their home to the invader,
for the monster to take life,
imprison and destroy light.

Assad Cina

DEEPER DIMENSIONS - CULTURE, YOUTH AND MENTAL HEALTH

BOOK REVIEW by Lisa Beasley
Coordinator, Hight St Youth Health Service

Snapshots from the Launch of Deeper Dimensions- Culture, Youth and Mental Health



From L to R,
Michael Kohn, Marie Bashir,
David Bennett, Nisha Alexander



From L to R,
Maria Cassaniti, Andrew Sozomenou,
Mariano Coello, Marie Bashir,
David Bennett, Abd-Elmasih Malak

Deeper Dimensions - Culture, Youth and Mental Health commences with an informative and interesting literature review that highlights the mental health needs of young people from culturally and linguistically diverse backgrounds. Setting the scene for the chapters that follow, the literature presented is rich in scope and detail and provides the reader with a clear and concise picture of the needs of young people from culturally and linguistically diverse backgrounds. Drawing on international, national and state evidence, the literature review encapsulates a way of thinking about a population's health in a logical, analytical and relevant manner. *Deeper Dimensions — Culture, Youth and Mental Health* achieves a synthesis of important aspects of positive mental health promotion, public health, clinical health care practice, epidemiology and social administration and community development.

Flowing on from the literature review, the book makes effective use of a series of chapters crucial to understanding the mental health needs of young people from culturally and linguistically diverse backgrounds. Each chapter provides the reader with a great many examples from a variety of organisations, agencies and individuals that extend the understanding of the presented issues. The chapters are also effective in extending our understanding of how strategies can be successfully utilised to address the needs of this population.

The format of the book provides movement back and forth from concept to evidence to practice. This flow engages the reader with interest in the concrete reality of the situation. The strategically chosen chapters provide the reader with a broad perspective that embraces both medical and social views of mental health, highlighting a conceptual basis which can facilitate communication amongst those in the field whilst simultaneously promoting resilience factors in young people and the crucial importance of promoting positive mental health.

Deeper Dimensions — Culture, Youth and Mental Health is a remarkable book that draws on the knowledge, skills and working experiences of those professionals leading the way in working with this population with complex needs. On the cutting edge of youth health practice, the chapters contained in this book will provide readers with a range of informative and effective strategies to enhance their current work practices.

Copies of the book are
available from the NSW
Transcultural Mental
Health Centre
Cost (incl. GST): \$22
Tel: 02 9840 3800

Synergy Spring 2000

FIRST FORUM OF THE SA TRANSCULTURAL MENTAL HEALTH NETWORK

PROMOTING MULTICULTURAL HEALTH AND WELLBEING

Looking to the future for communities,
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The forum aims to bring together multicultural community groups, carers, and service providers to look at the issues surrounding the wellbeing of multicultural Australia. The forum will address a range of themes including rural and remote issues.

17-18 NOVEMBER 2000

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COST

The forum is open to community member, service providers, policy makers, educators and managers.

The Conference fee is \$25
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Service
ABN 557 4887 4335

ENQUIRIES

All enquiries for presentations
and registrations please contact:

NESBWEB Forum Convenors
21 Market St
Adelaide 5000

Tel: 08 8200 3900
Fax: 08 8200 3949

Members of the NESBWEB, Transcultural Mental Health Network of SA have been busy working on a number of developments in the state.

The forthcoming forum: Promoting Multicultural Health and Wellbeing is the first forum of the network and has required considerable planning and collaboration by members. We are excited by the forum as an opportunity to raise further interest in multicultural mental health for both service providers and community members.

We are also very encouraged by the attendance of many well known contributors the transcultural mental health area in Australia. The SA network will be utilising the forum to generate future directions for its functions as well as contribute to a state directions paper. Participation by interstate visitors will be central to this process.

Finally the forum will provide an exciting basis to launch the network and its work to the general public.

PROGRAM SERIES

This year has seen the Network undertake a number of sessions on transcultural mental health topics for workers and community members. 4 sessions were arranged

have featured presentations of the work of numerous network members. Topics covered included prejudice in professional nursing practice, schizophrenia in the multicultural context, the mental health needs of younger NESB people and assessment issues for older people of NESB. Over 150 attendances were recorded across the four sessions.

The program series is currently being evaluated and is likely to run again in 2001.

RECIPROCITY IN EDUCATION PROJECT

A further area of work for the network has been the development of the Reciprocity in Education Project which is an ATMHN funded national project. Nicholas Procter

(Project Manager) the project team, the participating community groups and the steering committee have seen the project already achieve numerous outcomes in developing a model of shared learning in the experience of depression. Readers are advised to read the feature update of the project in Synergy on page 10.

CHANGES TO SA'S MENTAL HEALTH SYSTEM

The general mental health sector in South Australia is in an interesting position following the release of the 'Brennan Report' on Mental Health Services in South Australia and the response by the Department of Human Services, A New Millennium: Implementation of a 5 year plan for Mental Health Services.

There are very significant changes planned for metropolitan and rural mental health services in the State. These include a more centralised system of mental health networks, more strategic leadership and policy development frameworks, increased support for community accommodation services, further directions for mainstreaming of services, and changes to the extended care services.

These documents and proposed changes to the sector provide a challenge to those interested in transcultural mental health in South Australia. There are considerable opportunities for encouraging development of more culturally responsive services, particularly as there will increased attention of the quality and performance of mental health services and the measurement of these against national mental health standards.

In response to the plans, the network will be working to inform the Department on the issues for the State and well as participate in the planning of directions.

For more information on Network activities, please contact:

Ms Toni Crisci
Network Convenor
Tel: 08 8130 1300

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For further information on these projects, please contact the QTMHC
Tel: 07 3240 2833

Mr Ivan Frkovic, previous Manager of QTMHC, has taken up a position with the Mental Health Unit to implement the Mental Health Promotion and Prevention Policy. Ms Polly Nip has been appointed as the Acting Manager until a new Manager is employed. We wish Ivan well in his new position and thank him for all his support and input over the years.

In the last three months, the QTMHC has completed three projects/groups and also initiated some new joint projects with other key organisations in Queensland.

PROJECTS/ GROUPS COMPLETED INCLUDE

The action research project with Horn of Africa Communities has been completed. The final project report was launched on 14 September, 2000. Interested parties can contact the Australian Red Cross Brisbane Branch on (07) 3835-1550 for a copy of the report.

The Mental Health Interpreter's Course, a joint initiative with the Southbank Institute of TAFE was completed at the end of August, with 15 interpreters of 11 language groups completed the training.

The Transcultural Clinical Consultation Service in conjunction with the Ethnic Mental Health Program and the Princess Alexandra Hospital (PAH) Division of Mental Health have worked together to modify the Family Support Program developed by Dr Robert Blank to meet the needs of six ethnic groups. The six groups include Chinese,

Croatian, Greek, Italian, Spanish and Vietnamese. The Spanish-speaking group has held with very positive feedback. The next group is at preparation stage.

NEW INITIATIVES

The Transcultural Clinical Consultation Service and the Assessment Service of PAH Division of Mental Health is currently

working on an early intervention pilot project. The aim of this project is to develop a strong partnership between the mainstream Assessment Service and the Transcultural Clinical Consultation Service. Cultural consultation will become part of the assessment process and a culturally appropriate care plan will be developed to meet the needs of consumers from diverse backgrounds. The two services are now working on referral protocols.

The QTMHC is also involved in a partnership with the Ethnic Mental Health Program and the Cathay Club (a Chinese welfare organisation) to organise a Chinese Mental Health Forum during Mental Health Week. The program includes a information display in three locations and a seminar on mental health issues for Chinese community leaders and workers.

In order to address gambling issues among people from diverse cultural backgrounds, the Centre and the Multicultural Development Association is organising a half day seminar called 'Taking a Gamble – Response to problem gambling within ethnic communities'. The keynote speaker is Associate Professor Alex Blaszczyński from the University of NSW. The seminar will be held on 17 October, 2000 from 9.00am to 12.30pm. For further information, please contact Marina van Kooten-Prasad on (07) 3240-2833.

Finally, the Centre has been working in partnership with community organisations to lodge funding submissions for two new projects. The first project involves the development of an action plan to develop a Multicultural Disability Organisation in Queensland's NGO sector. Disability Services Qld and Multicultural Affairs Qld (MAQ) are considering the funding submission. The second project is a joint initiative with a coalition of five organisations lodging the funding application for a Multicultural Aged Information Dissemination Project. The application was submitted to MAQ.

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A Transcultural Innovation

Establishment of a Transcultural Advisory Group at Royal Perth Hospital

The Transcultural Advisory Group was established by the Transcultural Psychiatry Unit, the Language Services Unit, and the Speech Therapy Unit, at Royal Perth Hospital. The Hospital treats a very mixed socio-economic and multicultural group thus requiring its services to be responsive to the wide range of needs of those groups. Our respective experiences and observations of service provision to RPH patients from culturally and linguistically diverse backgrounds led us to identify a need for the Hospital to have a committee that would act as a consultative advisory body to oversee/monitor patient-related issues of a multicultural nature. The Transcultural Psychiatry Unit's equally instrumental role in founding this Group arose from our awareness that, despite our statewide mandate to address the mental health needs of people from CALD backgrounds, we are cognizant that for any CALD background patient utilizing the range of hospital services other than its mental health services, issues of a transcultural nature would inevitably emerge, to be satisfactorily and appropriately overcome by both staff and patient.

Examples of issues which TAG has tackled since its inception include: addressing various problems with interpreting issues; examining the suitability and availability, of translated material and tools in wards and departments; organizing the inaugural 'Harmony Day' multicultural activities at the Hospital to promote awareness of multicultural issues in Hospital service delivery. To date, we continue to monitor the extent to which the cultural and linguistic needs of ethnic community patients are appropriately met by services at Royal Perth Hospital.

TAG now has cross-representation from community service providers, including general practitioners who often refer their CALD background patients to RPH, consumer representatives, and practitioners working within the various departments and wards of the Hospital who on a daily basis, actively deliver health care to CALD background patients.

We believe that the establishment of TAG serves to enhance the overall quality of Royal

Perth Hospital services and its mandate is consistent with the Hospital's vision statement regarding continuum of care.

THE TRANSCULTURAL ADVISORY GROUP AWARDS

Consistent with its overarching function of consciousness raising of transcultural issues in health and mental health service provision the Transcultural Advisory Group has proposed, and recently received endorsement for further developing an initiative to present, by 2001, a Royal Perth Hospital 'TAG Award for Excellence in Transcultural Health Care Delivery'. Though the concept is currently very much in its developmental phase, it is proposed that the Award will be promoted within the Hospital and will be presented annually. Its aim is to encourage all departments and wards at Royal Perth Hospital to focus on strategies which would reflect cultural awareness and cultural sensitivity in service delivery, within their respective work environments. This will be an innovative 'first' for Royal Perth Hospital, as it clearly places the onus on health care professionals working at the 'coalface' of service delivery – ie. practitioners who actively provide health care to people from CALD backgrounds – to develop and implement ideas, based on their expert understanding of the nature of the service they provide, on how to make their CALD background consumers more at ease while receiving services, in a more 'culturally-friendly' as well as 'user-friendly' environment.

The Transcultural Advisory Group strives to ensure optimal service provision to the culturally and linguistically diverse patient population of Royal Perth Hospital. Therefore, principles for the proposed Award will be underpinned by 'best practice' protocols which include overcoming barriers in communication, and ensuring equity and access to hospital services for CALD background patients.

For further information
please contact the WA TPU
Tel: 08 9224 1760

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views

Assoc. Professor Harry Minas is Director of the Centre for International Mental Health, University of Melbourne and of the Victorian Transcultural Psychiatry Unit.

Paper presented at the 35th Annual Congress of the Royal Australian and New Zealand College of Psychiatrists, Adelaide, May 2000.

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news & views

Culture and Psychiatric Education

Our current training programs prepare graduates to work in a society that no longer exists and to work in ways that are no longer acceptable to those for whose benefit we work. One would think, by looking at our training programs, that there is a remarkable uniformity and consensus concerning what constitutes a life worth living and how such a life should be lived. One would also think that our ideas about health and illness, and what should be done in the presence of suffering, were universally applicable and uncontroversial. One would be justified in assuming that communication is not a problem worthy of much consideration. Further, it would seem, from what we choose to teach, that issues such as the politics of knowledge and of practice, privilege, and the distribution and proper use of power, were settled long ago. And finally, one would have to concede that psychiatry is essentially a technical discipline, no different really to any other occupation that requires some identifiable body of specialised knowledge and a range of technical skills, the application of which can repair dysfunctional brains or minds.¹

The difficulty is that our local worlds, and the world at large, have changed beyond recognition. In the latter half of this century Australia and New Zealand have become much more open societies, with a greatly increased two-way flow across their boundaries of information and ideas, money, goods and, most importantly for our purposes, people.

Associated with this increased openness of the system is an increased level of complexity, by which I mean a vast expansion in what is possible². There are many examples of this, in the realm of ideas information exchange, commerce, religion and politics. When sick, it is possible to seek the assistance of a doctor, psychologist, herbalist, chiropractor, iridologist, faith healer, or accupuncturist. All this in a bewildering range of languages. And yet, the fact of enormous cultural and linguistic diversity has had surprisingly little impact

Assoc. Professor I. Harry Minas

on our conceptions of medicine, the structure and operations of medical institutions and health care systems, medical education and clinical practice.^{3,4} Psychiatric knowledge and technical skills are as necessary as they ever were but are no longer sufficient. Assumptions that were comfortably made by doctors and patients about each other, because they came from essentially similar backgrounds, can no longer safely be made.

In culturally diverse societies, where there are no fixed, universally acceptable criteria for ethical judgment,^{5,6} doctors and patients are likely to hold diverging views with regard not only to the moral probity of various acts and interventions, but also with regard to the moral significance of pain, suffering, death, and life itself.⁷ In the cross-cultural clinical encounter, one of the key difficulties is that the physician and patient meet as moral strangers, in that they cannot assume what the moral viewpoint of the other will be. Their views of what constitutes a life worth living and the purposes of health care are likely to appear strange and exotic to each other. The moral commitment of the physician in these circumstances must be to the good of the patient *as the patient conceives it*.^{8,9} The skill required of the clinician is in gaining an understanding of the patient's conceptions of health, illness and treatment, and in being able to work collaboratively with the patient and family on those things that are most important to the patient. Beyond the clinical consulting room there are issues of equity and justice in which psychiatrists must take a vital interest and play an active role.^{1,10,11}

How should we educate psychiatrists so that they can work effectively in such a world? The first point I would make is that we should no longer speak of postgraduate training but of postgraduate education. This is not a trivial change in language but reflects a different view of the purposes of education and of training. The definition of education that I prefer comes from Lloyd's *Encyclopaedic Dictionary*,¹² published in London in 1895. It is still surprisingly relevant.

Education is: "Properly the educating, leading out, or drawing out the latent powers of an

individual...Education...begins when one enters the world, and continues all the time he is in it. In a more specific sense, it is used of a premeditated effort on the part of parents, teachers, professors to draw out one's intellectual and moral endowments, encouraging what is good to oneself and to society, and discouraging what is hurtful. With this is combined an effort to give more or less of technical training to fit the scholar or student for the occupation by which he desires or is likely to support himself in life...[E]ducation comprehends...the formation of the mind, the regulation of the heart, and the establishment of the principles..."

In our current education programs much time and effort is spent on the task of "formation of the mind" and, particularly, on fitting the scholar "for the occupation by which he desires or is likely to support himself in life." However, the formation of the mind does not occur in a cultural vacuum. Mind is constituted by and realised in the use of human culture.¹³ Learning is always situated in a cultural context and is always dependent on the use of cultural resources. Education must be conceived as enabling students to use the tools of meaning making and reality construction, to better adapt to the world in which they find themselves but also to change the world to better fit it to the needs of those who live in it.

While we pay close attention to the intellectual development of our students, the above definition suggests that a key function of education is also to "draw out one's...moral endowments, encouraging what is good to oneself and to society, and discouraging what is hurtful." Psychiatric education must surely be more than an instrumental means to an occupational end. Graduates should be prepared (able and willing) to participate effectively and constructively, and to provide leadership, in the wider affairs of society.

In promoting certain changes in curriculum, and more broadly in the culture of the profession and of the College, we should be clear about the characteristics that our curriculum and the professional culture should imbue in our graduates.¹⁴ The life of

the profession and of the College depends on the quality of its graduates. This quality can not be seriously evaluated until many years after graduation, and is judged as much by the sort of people graduates prove to be as by what they know and can do¹¹. The long-term character and achievements of our graduates will determine whether the profession and the College will grow in the esteem of the communities they serve. What might some of these characteristics be? I will suggest a few for the purpose of discussion. They must, of course, be fine scholars, with a lifelong passion for learning. On graduation, in terms of their clinical skill, they should be among the best in the world, and remain so throughout their working lives. They should have the capacity to exercise these skills for the benefit of people from a very wide range of backgrounds. They should have a firm commitment to the public good, as well as to the good of their individual patients. They should not crave too much power or privilege and be able to work with others (patients and their families, and other health professionals) in a genuinely collaborative fashion. They should be resolute in their defence of justice and in their opposition to injustice and discrimination. Some of these educational goals have to do with "the formation of the mind" and some with "the regulation of the heart, and the establishment of the principles."

What should be taught?^{15,16} The general objectives of education in culture and mental health are that students will:

- Gain an understanding of the experiences of people from different cultural backgrounds living in Australia, and the difficulties many of them face in getting access to effective mental health services.

- Understand the history of migration to Australia within the wider social and political context, and the mental health implications of migration and settlement patterns, with a particular focus on the more vulnerable groups, including refugees and survivors of trauma and torture.

- Understand the social and mental health consequences for Aboriginal communities of European settlement, and of the continuing failure of successive

governments to find solutions to the appalling social and health problems confronted by Aboriginal and Torres Strait Island communities.

- Develop a sound understanding of the concepts of ethnicity, race, culture and nationality, and understand the relevance of such concepts for psychiatric nosology, assessment and treatment, and for public mental health policy, service design and evaluation.

- Gain a basic knowledge of the epidemiology of mental illness across cultures, the methodological issues involved in conducting research in this area, and the debate about the applicability of concepts of psychiatric illness and treatment developed in the Anglo-American cultural context to people from different cultures.

- Develop skills in cross-cultural psychiatric assessment, and have an appreciation of the theoretical and practical issues involved in cross-cultural treatment.

- Develop frameworks for thinking about public mental health policy and service design and evaluation as these are relevant to people from different cultural backgrounds.

When asked what gave impetus to his writing the Peruvian author Mario Vargas Llosa¹⁷ had this to say:

Ever since I was young, it has been my ambition to become a citizen of the world. Not to feel limited or conditioned by geography or culture or creed. If a man really wanted to be free, he had to be able to circulate freely not only in physical space but also among cultures, languages and beliefs. Without renouncing, of course, the formative experiences of life, which, in my case, are Peruvian. I don't want to feel like a foreigner anywhere. If there is for me a fundamental idea of civilisation, it is this.

A psychiatrist working in Australia or New Zealand now and in the foreseeable future needs to develop a similar freedom of movement if he or she is to be able to serve the community in which he or she works. The graduates of our education programs should be at home in the world,¹⁴ with the

ability to move freely among the many cultures that constitute our two countries, and with the capacity and the wisdom to re-fashion cultures (including the culture of our profession) so as to better fit them for the needs of their members and the needs of future generations.

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FECCA Conference 2000

Multiculturalism and Harmony – Building a New Future

FECCA (The Federation of Ethnic Communities' Councils of Australia) holds a national conference each year in one of the State/Territory capital cities. These are prestigious events, attracting over 300 people including official delegates and other interested parties from across Australia and overseas.

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Placing Bilingual Mental Health Workers In General Practice Small Steps In The Shared Care Process

The NSW Transcultural Mental Health Centre, in collaboration with the Western Sydney Division of General Practice, is currently conducting a pilot project aimed at providing practical support to general practitioners in managing the mental health care of their patients from non-English speaking backgrounds.

THE APPROACH

It is seeking to do this by placing five bilingual mental health workers, who are currently employed by the Centre as sessional workers, in a general practice for half a day per week. The clinical phase of the project runs for a 16-week period, from the beginning of September to the end of December. During this time the five participating GPs will be able to refer

patients to the bilingual worker for assessment and a brief treatment intervention of up to eight sessions. While the GPs have been asked to refer patients who have recently presented with symptoms of anxiety and depression, other referrals can be negotiated. At the end of the treatment period the GP will be provided with a report focusing on recommendations for future

care. Both parties are being encouraged to maximise the collaborative aspects of the project by discussing individual patient progress, as well as broader issues relating to the mental health care of the patients seen at the practice.

SELECTION OF THE PRACTICES

In the first instance large group practices were identified through the Division's membership list, with particular emphasis being given to an area of Western Sydney with a high concentration of specific ethnic populations experiencing significant socio-economic disadvantage. While two practices were eventually recruited with a high patient load from the local Turkish community, there were considerable difficulties in engaging GPs in the project. Apart from the time pressures experienced by all GPs, some were concerned about introducing a service to their patients that could not necessarily be maintained beyond the pilot phase. As the practices also had no prior contact with the Transcultural Mental Health Centre, there was no existing

relationship upon which to build. A different strategy was therefore adopted, in which the sessional workers identified bilingual GPs working in smaller practices. Once they had established an initial level of interest, a brief letter outlining the aims and parameters of the project was faxed to the practice, and a meeting between the GP, Project Officer and sessional worker occurred. A more detailed letter was then sent to the doctors who agreed to participate.

EVALUATION

The GPs will complete three questionnaires during the course of the project. The first concentrates on patient and practice characteristics overall, as well as the individual GPs confidence with diagnosing and managing the mental health problems of their non-English speaking background patients. The second focuses on what, if any, symptom change they perceive in the patients they have referred to the bilingual worker, and the third asks them to comment on the usefulness of the placement process overall. This final questionnaire also asks them to consider their ongoing training needs.

As well as evaluating the progress of individual patients, the bilingual workers have also been asked to reflect on the process of working within general practice by keeping a weekly diary. It is hoped that this will assist in understanding the dynamics that either promote or hinder a more collaborative approach in general practice.

THE BROADER CONTEXT

The pilot is being conducted in conjunction with the development of a broader partnership process between the Western Sydney Division of General Practice and the Western Sydney Area Mental Health Service. The Project Officer from the Transcultural Mental Health Centre is working closely with the Area's GP Liaison Officer and the Division's Mental Health Program Manager to ensure that the additional issues faced by GPs working in a culturally diverse environment are identified. To date a series of local meetings has been conducted at Community Health Centres throughout the Area to bring the parties together. Apart from giving interested GPs the opportunity to meet their local mental health team, these meetings also provided a forum to promote TMHC's Clinical Services to GPs and encourage their use of the service.

Primary Mental Health Care for Older People from Culturally and Linguistically Diverse Backgrounds

The important role of the General Practitioner in the provision of primary mental health care to older people from culturally diverse backgrounds was highlighted in a recent study conducted by TMHC. This study was part of a project funded by the Commonwealth Department of Health and Aged Care which aimed to promote the mental health of older people through a community education campaign. It sought to identify the major mental health issues concerning older people, their service needs and their preferred primary sources of help and information. A survey was also conducted among service providers and the findings compared with those of the older people consultations.

According to the ABS Census, 1996, older people born in non-English speaking countries constitute 17.8% of the Australian population aged 60 years and over with 20% of this NESB population living in NSW. This older population group is expected to increase by a significantly greater proportion (79%) than the Australian born population (29%). In spite of these statistics, a literature search carried out by the study showed that research into the mental health needs and issues for Australia's diverse older population has received little attention to date.

In order to establish a baseline understanding of their concerns, a number of focus groups were conducted with older people from the 15 language groups targeted for the community education campaign: Arabic, Cantonese, Croatian, Dutch, German, Greek, Italian, Macedonian, Maltese, Polish, Russian, Serbian, Spanish, Vietnamese and a 'multicultural' group consisting of older people from smaller communities. It is interesting to note that, although the sample of older people consulted was biased in favour of those with some social networks, results indicated that their knowledge and information about mental health and services was still very limited.

The focus groups discussions covered a wide range of issues. While a number of issues were common to the majority of language groups, some were seen to be of greater significance by some groups than others. Length of stay

in Australia was seen to be a factor impacting on emotional health, with those who were already older when they migrated, e.g. under the Family Reunion Program, experiencing additional adjustment related problems to those who had grown older in Australia. The major commonly identified issues affecting the mental health of older people were: isolation and loneliness, transition and loss, changed role within the family, language and communication, financial dependence, stress, effects of refugee experience, anxiety and fear, depression.

The General Practitioner was seen across the board as the most important source of help and information about mental health problems, especially when the doctor spoke the same language as the older person. Community Centre workers or social workers who spoke their language, as well as religious advisers, were also seen to a lesser extent by some as a source of help. Lack of understanding about mental illness and stigma were major barriers in accessing other sources of help. Some older people stated that they would be insulted if asked to see a Psychiatrist, others claimed that they didn't understand what "mental health services" meant. Because of their embarrassment or lack of understanding to talk about problems in terms of mental health, it was easier for them to talk about physical health, e.g. feeling nauseous, dizzy, short of breath, sleeplessness.

This tendency of older people to somatise their emotional or mental distress can be seen as another factor in their seeking help in the first instance from a GP, who was also seen as their primary source of information. However, issues were also identified with regard to the help given by GPs, particularly to the prescribing of "pills" which were seen as not taking the problem away.

Language was also seen as a major problem in communication with the GP. The older people complained that they had difficulty in

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Primary Mental Health Care for Older People from Culturally and Linguistically Diverse Backgrounds *continued*

being understood so they were given the wrong treatment or didn't understand the treatment. Use of an interpreter was seen as unsatisfactory as it was too hard to explain feelings through an interpreter. A doctor who spoke the same language was seen as a tremendous benefit: "Being able to speak to the doctor [in their language] already makes them feel better."

In order to compare service providers' perceptions of these issues with those of the older people, surveys were conducted across NSW among both mainstream service providers and those specifically caring for older people from NESB, with almost 200 responses received. With regard to sources of help, the most common response from service providers was that they would refer an older person from NESB with a mental health problem to a General Practitioner. This could be seen to indicate an awareness among key service providers that NESB older people would not use existing mainstream mental health services, a finding supported by the literature and service utilization data. There was agreement by both service providers and older people that the GP is the preferred primary source of help for NESB older people with a mental health concern and their carers.

This finding places a tremendous burden on General Practitioners, with the expectation that they are the primary providers of mental health care even though they may have limited skills with regard to mental health generally and mental health for older people from NESB in particular. The tendency of older people from NESB to somatise mental or emotional health problems has the potential to further impact on communication difficulties, leading to incorrect diagnosis and treatment. Some GPs' lack of information about or familiarity with available mental health and support services may also limit referral options.

The Commonwealth has acknowledged the significant role of GPs as primary care givers in the area of mental health through its national GP Mental Health Shared Care Programs, which are administered through the states. The NSW Transcultural Mental Health Centre is currently working on a GP NESB Mental Health Shared Care Project, which is seeking to raise GP awareness of these issues identified for people from culturally diverse backgrounds including older people. It is critically important that transcultural mental health issues are integrated into all aspects of the national Shared Care Programs in order to respond effectively to the needs of Australia's diverse population.

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It is not only those factors associated with the patient's sociocultural background that might influence the rate of detection of mental health problems. It also may be the GP's lack of experience in eliciting appropriate information from people of CALD background, or a possible lack of GP confidence, and ability (Mihalopoulos et al, 1999). Cross-cultural consultations will inevitably require more time than is available in order for a 'negotiation of explanatory models' to occur whereby differences in belief systems are acknowledged by the patient and the doctor, and attempts are made by the doctor at reconciling these differences (Kleinman et al, 1978).

Mihalopoulos and colleagues reported that the Royal Australian College of General Practitioners has no 'formal' policy concerning service delivery to people from culturally and linguistically diverse backgrounds. However, the comment is made that this should not be taken as a lack of commitment by the RACGP given that 'educational initiatives emerging from the College do include provision for people from non-English speaking backgrounds' (pg.12)

ENHANCING GP EFFICACY IN RESPONDING TO MENTAL ILLNESS PRESENTATIONS TO CALD BACKGROUND PATIENTS

The World Health Organization (1973) described general practitioners as 'well placed' to deliver primary care of mental illness. Among the reasons qualifying GPs for this position is that mental disorders presented to them are typically associated with a dysfunctional psychosocial element which could facilitate the GPs understanding of the problem. WHO posits that while a psychiatrist may require lengthier consultation time to obtain relevant information, the GP, through their daily encounters with psychosocial issues presented by their patients, 'will carry much of this

understanding in his or her head' (WHO, 1973). However, the consultations and document review comprehensively undertaken by Mihalopoulos and colleagues identified a range of issues that might impede GPs from fulfilling this 'ideal role'. With specific reference to mental health care provision to people of culturally and linguistically diverse backgrounds, Mihalopoulos et al (1999) ascertained that the GP's role is either, ill-defined, or limited due to being 'under-equipped, facing structural barriers and barriers associated with their own knowledge and confidence levels' (pg. 61)

A recommendation included by Mihalopoulos et al (1999), and reportedly advocated by the Joint Consultative Committee in Psychiatry (1997), is the development and delivery of appropriate training for primary care providers. Such training "includes training offered at undergraduate level by medical schools, at postgraduate level by the Royal Australian College of General Practitioners, and in an ongoing fashion through continuing medical education initiatives run by Divisions of General Practice. Training should promote cultural sensitivity, and should prepare GPs for dealing with patients from different language groups..." (pg.65). Based on this particular recommendation, the Primary Care Mental Health Unit of Western Australia saw a need for an innovative training program for GPs focusing on CALD background patients and their mental illness presentation. The Primary Care Mental Health Unit is a Centre of excellence for providing education and research for primary care practitioners (primarily GPs) in the area of mental health; and, whose function includes development and delivery of mental health training programs to primary health care practitioners.

The training program was designed in consultation with a consortium of health and mental health practitioners who have wide expertise in

transcultural mental health. The Steering Committee included representatives from the Primary Mental Health Care Unit (PCMHU), Department of Psychiatry and Behavioural Sciences, University of Western Australia; The Transcultural Psychiatry Unit (TPU), Royal Perth Hospital; and Curtin University of Technology. Input was also provided from independent general practitioners.

AIMS AND OBJECTIVES OF THE CROSS-CULTURAL TRAINING PROGRAM

Application of presented information surrounding cultural issues associated with belief systems and illness behaviour and illness presentation, is integral to meeting the training objectives. Recognition of idioms of distress in CALD background patients requires vigilance towards the meaning of somatic complaints and non-verbal cues (Bernardi, 1996). The broad aim of this training program is therefore to improve the general practitioner's ability to better understand and communicate with their patients from culturally and linguistically diverse backgrounds. At the same, such training should also help them avoid making cultural generalizations and 'cultural blind spots' (Carillo et al, 1999).

A desirable outcome of this training is for GPs to confidently, and competently, bridge the cultural gap caused by two world views of the presenting problem by explaining the problem in terms and concepts reflecting the patient's explanatory model.

In view of the above, specific objectives of this training are:

To enhance the skills of detection and clinical diagnosis of mental illness with clients from CALD background in order that early intervention strategies may be implemented to minimize the likelihood of acute presentations in psychiatric facilities.

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To improve the management of mental illness amongst CALD groups by GPs and facilitate the timeliness of referral along the pathway to appropriate mental health services.

To promote among GPs the fundamental attitudes of curiosity and respect into their consultations with patients from culturally and linguistically diverse backgrounds (Carillo et al, 1999) in order that a non-judgmental and safe environment be generated in which explanatory models may be reconciled.

PROCESS OF TRAINING PROGRAM DEVELOPMENT

The program was designed after conducting a training needs analysis among GPs which posed a series of questions pertaining to needs identified by GPs for a training series about mental health issues in CALD patients. The results of this needs analysis suggested that there was a demand for such training for GPs within metropolitan Perth. Our findings supported those of Mihalopolous et al (1999).

SELECTION OF CULTURAL GROUPS FOR PRESENTATION

The needs analysis also examined which cultural groups GPs felt were needed to be included in the training program. Ascertaining groups to be targeted was a difficult task. In addition to considering results from GPs interviewed, statistics on recent migrants to Western Australia were also taken into account. For example, settlement of migrants from the African continent had recently been increasing in Western Australia, and it appeared their numbers would steadily continue to rise. The majority of these migrants were in WA seeking refuge from war torn nations and may have experienced psychological trauma during their escape from their homeland. This fact would indicate a high prevalence of unaddressed mental health needs. Given that many people from CALD backgrounds prefer to see GPs who speak the same language, one

would assume that for the increasing number of African migrants, this preference is unlikely to be realized. To our knowledge, there are at least two general practitioners practicing in WA who are of African origin. In light of this, it seemed reasonable to deduce that most of the African migrants would have to seek consultations with 'mainstream' GPs.

In order to assist a primarily English-speaking background (ESB) GP population in their cross-cultural consultations with patients of African backgrounds, we decided to include the African cultures collectively in one session of training. Our aim here was to address some of the cultural commonalities that might arise from the African communities. We acknowledge that this was not an accurate representation of the cultural and religious diversity within Africa, but in order to do this vast continent justice, we would need to have spent four or more sessions focussing on the continent alone. As this was a pilot project, we included the African nations under an umbrella of one session and to ascertain from this introductory session, further training needs of the participants specific to African communities. Results of the evaluation after this and other sessions would help determine where GPs felt training should be targeted in order to fulfil their practice needs.

After discussions with GPs, examination of the relevant statistics, and consultations with relevant stakeholders, the Steering Committee decided that the following groups would be included in training:

Polish, Italian, Vietnamese & Chinese
Indian Subcontinent, Croatian, Indian
African Communities, Australian
Aboriginals.

Due to the difficulty of presenting a true representation of all migrants in WA, some communities were combined and/or condensed under an umbrella 'cultural identity'. They were grouped according to cultural

similarity. We did not, in any way, wish to suggest that grouping cultures indicated total cultural similarity. The grouping process simply facilitated the presentation of similar cultures and discussion of a greater number of cultural groups than our time schedule permitted. This process also highlighted cultural similarities and differences between groups who may be geographical neighbours, hence illustrating individual differences, and heterogeneity within the cultures. This is a feature often overlooked by many practitioners.

Although Australian Aboriginals are not an ethnic population, they were included as a result of the needs analysis undertaken. Additionally, the culture of the indigenous population is markedly different to that of mainstream Australia. Hence by including this group, we acknowledged a need for better education of GPs about Aboriginal culture, in particular, Aboriginal health and mental health beliefs. Through this process, we hope to contribute to the improvement of the mental health care of indigenous Australians.

MATCHING MENTAL HEALTH ISSUES TO CULTURAL GROUPS

We aimed to expose general practitioners to mental health issues as it is likely to be presented, at their practice, by people from CALD backgrounds. It is not feasible, nor pragmatic for GP participants to learn about each culture. Therefore, it was decided that a more practical approach is to present GPs with culture-specific problems that are likely to occur in cross-cultural consultations, related with a given culture, and provide applicable information on how to identify and deal with these.

A mental health topic was assigned to each cultural group, for presentation and discussion. The topic was illustrated via case presentation by the facilitating GP. Consultations with practitioners, health workers in the

transcultural mental health field, the Steering Committee, and the results of the needs analysis, all served to inform the assignment of a given topic to a specific cultural group. Particular attention was paid to anecdotal evidence, based on practitioners' experiences and observations of which cultural group predominantly presented with which mental health issue. For example, results of our consultation process indicated that post-traumatic stress disorder was reportedly more prevalent in the African migrant population than other migrant populations. The mental health topics finally selected for the training were fairly broad based, with some specific reference to a mental disorder. The list below describes the themes presented, and to which cultural groups they were assigned.

| | |
|----------------------|----------------------------|
| Polish | Loss & Grief |
| Italian | Pain Management |
| Chinese & Vietnamese | Somatization |
| Indian Sub. | Depression |
| Croatian | Domestic Violence |
| Iranian | Anxiety |
| African Comm. | Post-Traumatic Disorder |
| Aus. Aborigines | Major Psychiatric Disorder |

PROMOTING CO-PRESENTATION COLLABORATION BETWEEN GENERAL PRACTITIONER AND ALLIED HEALTH PROFESSIONAL

The Steering Committee thought it appropriate, and innovative for delivery of training at each session to be conducted by a general practitioner and an allied health professional, who themselves were of the same cultural origin as the culture presented for the session. Speakers for each session were advised not to present exclusively on the topic assigned, but to also include discussions of mental health issues which are salient to the community which they represent.

Traditionally, much teaching

conducted with GPs is delivered by other GPs. In our particular context, we considered that choosing GPs of the same cultural origin to present a session on his culture would enhance the training. We believe that GPs can relate life experiences, as presented at their practice by CALD background patients, to factual information about culture and culturally specific aspects of mental illness. However, we also saw advantages in including allied health professionals as presenters. Firstly, there appeared to be some confusion amongst GPs as to the role of allied health professionals in mental health settings (e.g. Social Workers, Occupational Therapists, Mental Health Nurses, Psychologists). Similarly, many allied health professionals are not often aware of the GP's role in managing mental health issues of their patients. By allowing the opportunity for the disciplines to integrate, we hoped to clarify some of these issues. Secondly, many allied health professionals we approached to be presenters were practicing staff of larger service providers dealing with mental health (e.g. hospitals, mental health clinics etc). The sessions facilitated contact between the GP and the allied health professional, which will subsequently assist GPs with referral processes and provision of cultural and mental health information in the management of future CALD background patients who attend at their practice.

With the various disciplines collaborating on their presentation, GPs and allied health staff were able to acknowledge similarities and differences between their clinical approaches, skills and knowledge, with reference to cross-cultural mental health. A collateral aim of these sessions was therefore to enhance awareness and understanding between the disciplines and enable them to form a much better and effective working relationship.

Despite the guidelines developed for presentation format and structure,

presenters were, nevertheless, encouraged to exercise autonomy and flexibility with the delivery of their sessions. Some presenters chose to co-present both halves of the session. For example, for the session on Chinese and Vietnamese cultures, both speakers were GPs from the respective cultural background. One presented on Chinese culture and the other on Vietnamese culture. A similar anomaly arose for the presentation on the African communities. Due to the scarcity of GPs of African origin in WA, we obtained the expertise of two health professionals of African origin for the presentation. One of whom was a medical specialist in his homeland of Somalia, and is currently undergoing the process of getting his qualifications recognized in Australia.

APPLICATION FOR CONTINUING MEDICAL EDUCATION (CME) POINTS

Although the project was a useful and innovative approach to cross-cultural mental health training for general practitioners, with the demands continuously placed on GPs for their time, it was necessary to provide some incentive for attending training. Traditionally, this takes the form of Continuing Medical Education (CME) points. GPs are required to accrue a given number of CME points over a triennium period. Application was made to, and approved by, the WA Royal Australian College of General Practitioners (RACGP), for CME points for the program. This provided encouragement for GPs to attend the training. A further incentive was that GPs were given a choice of either registering for individual sessions, or for all eight sessions at a discounted price. A nominal fee was charged for sessions.

STRUCTURE OF TRAINING PROGRAM

The nature and venue of the training course needed to be appealing for GPs in terms of time, location, duration, and format. Sessions were held

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fortnightly in the evenings, starting at 7:00pm and concluding by approximately 9:00pm. The sessions were held at either of two of Perth's major teaching hospitals: Royal Perth Hospital, or, Sir Charles Gairdner Hospital. The locations were chosen for reasons of convenience of accessibility. Perth is expansively set out, stretching along the coast. Hence the hospitals selected provided a fairly central location, accessible by public transport. This easy access made it easier for general practitioners to attend the evening training sessions.

SESSION FORMAT

Each session was divided into two sections, separated by a break for a meal.

The first section included exposure to 'universal themes' deemed relevant for all cultures being presented. These included presentation of aspects of ethnic identity considered as 'universal' amongst a wide range of ethnic communities. Such dimensions include issues related to pride in ethnic background and language, liking for traditional and social factors of one's ethnic group and sense of belonging to one's country of origin (Nesdale et al, 1997). Also included under the universal themes were the people's history of migration to Australia, gender roles, cultural norms, social structure, illness behaviours, sick roles, and the understanding/acceptance of mental health issues within that culture. These 'universal themes' further helped define the similarities and differences between the ethnic and mainstream cultures, and assisted in differentiating between the numerous ethnic cultures presented. Issues deemed potentially relevant to a GP's understanding of his or her patient's unique cultural-related presentation of a mental health problem were also encouraged for presentation and discussion.

This first half of training was presented by the allied health professional whilst the second half focused on clinical case

studies and was presented by the general practitioner. The major emphasis in the second section was for the case study to be related to the theme or topic assigned to the cultural group presented (e.g. for Polish, Loss & Grief).

Sound theoretical knowledge is integral for learning the relevant facets of a given topic. However, practical knowledge helps to enhance and cement learning themes into working knowledge. By using case studies as a learning tool in the presentations, GPs were able to identify with practical situations that they may have encountered within their own practices. Identification with the cultural nuances inherent in a case example will assist in better understanding of treatment strategies in practical terms. This will facilitate application of theoretical knowledge at the clinical level. Hence, GP presenters of the given culture illustrated their knowledge of how to manage and treat patients from their culture by using case studies. Apart from informing on mental health issues in the CALD population, it was also envisaged that information derived from sessions would also assist with general rapport building in cross-cultural consultations; and a better understanding of CALD background patients when presenting to their GPs for miscellaneous health issues.

PROMOTION OF INTERACTIVE LEARNING

Session format and structure were necessarily interactive to allow mutual exchange of cultural and clinical knowledge and experience between the allied health presenter, the GP presenter and the GPs in the audience. The interactive process served to promote retention and recall of information as well as empowering the audience in the teaching process. In addition, by sharing their own personal experiences with the audience, presenters were able to dismiss existing cultural stereotypes and illustrate the culture both in the

country of origin, and the way it is presented in Australia. For example, the majority of Indian origin migrants in Australia are tertiary educated, but this is not so for the percentage of Indians living in India. Hence the point is made that issues for the migrant population may be far removed from those living in mainstream India.

This interactive learning environment is also conducive for the establishment of sound rapport between the speakers and participants, which is potentially advantageous for all involved. Participants will feel less hesitant about contacting a speaker or another participant for professional support, referral or consultation about a CALD background patient encountered in their practice. Furthermore, by interacting freely with the speakers and participants, the group can guide the speaker to address their training needs and focus upon areas of interest/concern rather than discussing areas which may not be as pertinent for the group.

EXPERIENTIAL LEARNING

For this project, we chose to use an experiential mode of delivery of the teaching materials. We aimed for participants to sample a 'taste' of the culture being presented. Therefore, presenters were encouraged to bring along materials or 'props' they felt would enhance the mood on the night – music, pictures, clothes, dolls in national costumes, maps etc. Some presenters came dressed in their national costume. Catering for each session was also sought from caterers who provided food representing the culture presented on the night, (eg. Iranian dishes for the Iranian session). This novel approach to teaching was aimed to engage the interest of the participants, thereby increasing their appreciation and understanding of the culture presented on the night.

OUTPUT

At the outset of this project, it was envisaged that a Manual would be

produced which would include an outline of the process by which the training program was developed.

The Manual would be based on information collected from evaluations conducted at the end of each session to measure usefulness and effectiveness of the sessions. Further to this evaluation, in-depth interviews would be conducted with general practitioners and presenters three months after the conclusion of the training program. Responses from these interviews would add to data obtained from standardized evaluation protocols. For example, GPs who attended the training would be asked whether they had since implemented any strategies they had acquired resulting from the training, during cross-cultural consultations. Also elicited by this process would be practical and clinical viewpoints that would enhance the relevance of this Manual for clinicians.

The format for this Manual will include a general section on the issue of culture and mental health and a section describing cross-cultural mental health issues, specific to different cultural groups, that were raised in the training. It would also highlight both significant commonalities and specific differences between cultural groups in relation to mental health issues. It is proposed that the Manual will serve as a tool or template for other centres wishing to deliver similar training. The Manual will have adequate details and practical guidelines so that the process we adopted will be transferable and flexible for use with modification deemed appropriate for different cultural groups, differences in style of presentation, and a different audience group (eg. allied health professional). The choice of cultural groups will depend on the demographics of a given area at which a particular service is located.

The Manual will also be made available to general practitioners and

other health providers. In this way, practical information on the specific cultural groups presented may be integrated into clinical practice.

SUMMARY

As the literature review, and thereby, the rationale for this initiative suggest, cross-cultural awareness training for primary care service providers is a significant step towards enhancing service provision for people of culturally and linguistically diverse backgrounds. Primary care services are less stigmatizing to access and are more conveniently located.

Previous research have confirmed that although the mental health needs of people from CALD background may be more similar to those of the mainstream Australian born, there are factors that will significantly deflect from the 'norm', the presentation of mental illness, its assessment and management.

Enhancement of the therapeutic alliance during a cross-cultural consultation will facilitate early detection and early intervention of mental illness presented at the general practice. For an effective therapeutic alliance to be formed between the patient and the professional, the professional must be able to understand his/her own culture-bound feelings, avoid stereotyping the client into a cultural group and objectively observe the differences between the two (Bland & Kraft 1998).

In effectively treating CALD background patients, the knowledge of the general practitioner concerning mental health must extend beyond the biomedical model. A holistic approach encompassing the psychosocial dimension and including an understanding of potential cultural constructs that may be underlying the patient's behaviour are fundamental to the therapeutic process.

Cross-cultural awareness training in primary care is imperative in an increasingly multicultural Australia.

To conclude, we believe that the process we have implemented above is but one of many ways that will serve to improve, at the grassroots level, mental health for a culturally and linguistically diverse population. ■

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One interviewer told of an experience in a suburban hospital, where:

one day the male nurse picked up a brick from the ground and he extended his hand ready to strike me with the brick. I remember that I was so scared. I started to cry. I know that they use force towards patients, bad treatment used to occur quite often

On the other hand, other major and suburban hospitals were rated extremely highly by patients:

The staff are of a very high standard, very carefully selected. They are very patient with you, have great listening skills and really know how to comfort you. I have a feeling that they are much better trained and have the right to be proud of their services. I would trust them in a time of crisis.

Certain key workers were also spoken very highly of, with comment like

[She] helps me to survive or it gave me a new life.

In both cases, it was the cultural sensitivity of these agencies, along with the ability of staff to communicate with patients in their own first languages, which contributed in large part to their perceived high level of service.

Support groups made up of people from the same ethnic groups were consistently mentioned as a positive strategy for therapy. Most people felt the need to express themselves in their own language, to therapists who could understand and respond in their languages. The general distrust of interpreters contributes to this. However it seems that providing a culturally sensitive, rather than necessarily ethno-specific, environment within which people could discuss their experiences would go a long way towards healing many people, given that most of the interviewees expressed primarily their desire for a safe, non-threatening place to express their feelings. For many, factions and conflicts within their

ethnic communities also contribute to difficulties in establishing any kind of ethnically-based support system.

INFORMATION DISSEMINATION

Few of the people interviewed have accessed the full range of services available to them; many have accessed none. Carers have commonly accessed a range of services for the person they are caring for, but are not aware of the support services available for themselves.

This seems to stem predominantly from a lack of knowledge of the services and what they do. Equally importantly, though, interviewees were unsure of how of how they would be received by the services. They were afraid that their problems would not be understood, or that people would not want to help them, and so did not make the first contact. As few people from these communities access services, they have no way of finding out how they would be received.

Apart from health service providers, almost every interviewee had visited Centrelink at some stage, many regularly, and most had attended English classes. But few had discussed their issues with the staff of these agencies. Most felt that this was not part of the staff's responsibility, or they did not feel comfortable raising personal issues with these staff members.

Ethnic media were also consistently raised as an effective medium of information dissemination. For this research, one of the Polish interviewers was interviewed on Polish radio. By the time she had driven home, there were four messages from people wanting to talk about their experiences with her.

INTERPRETERS

Unprofessionalism among interpreters was an issue which was consistently raised by interviewees. Only with the

Filipinas, both of whom spoke English, was this not a significant problem. They were not trusted, and their confidentiality was considered doubtful. Interpreters were frequently accused of behaving in a patronising way. Because of this, people who cannot communicate in English effectively face a double barrier in accessing services, not trusting either the interpreter or the service. Ultimately, mental health services cannot be made more accessible to people who do not speak English without addressing this issue.

Failure to use interpreters was a recurrent theme in the interviews. No clients reported using an interpreter with their GP, including many who said they could not communicate well in English. Even in one detention centre, interpreters were routinely not used for complex counselling and psychotherapy sessions with newly arrived migrants. One government counselling service refused treatment to a client because of the extra cost which interpreters would entail. It is probably a combination of this cost factor, a lack of knowledge about the interpreter booking system, and a failure to understand of the importance of using interpreters which leads to this situation.

Inappropriate use of interpreters was also raised. An Afghan woman was counselled about the death of her 22 year old son through her children, that is the dead man's younger brothers and sisters, which is clearly inappropriate. Another interviewee felt her problems were specifically exacerbated when she was forced by the staff of one hospital to discuss her infertility through a male interpreter.

ACCESS AND EQUITY

Difficulty in gaining access to services leads to a situation where people attempt to deal with problems themselves, within their community or more commonly within the family, rather than seeking outside professional help. But rather than this

being a choice, it is often perceived as the only option available.

It seems that many of the chronic, complex problems being experienced today by people who arrived decades ago stem from the fact that their settlement was not facilitated by any kind of service delivery, and they had limited access to any services which were sympathetic to their particular needs after their arrival. If this were present, perhaps much of the present disillusionment could have been avoided.

THAIS

No Thai women were able to be interviewed for this research, despite extensive efforts. Thai women are not accessing services, and refusing to use interpreters when they do. This situation seems to have been brought about by extreme stigma attached to issues of mental illness within the Thai community, which leads them to refuse to use Thai interpreters for fear of 'gossip'. This is undoubtedly compounded by the fact that many Thai women are not free to access services without their husband's knowledge or consent, another factor limiting their ability to find out about and then use appropriate services.

Undoubtedly Thai women are not alone in their reluctance to access services for reasons of stigma, confidentiality, lack of information, and restriction by family members. Efforts must therefore be made to identify other groups which may be similarly disadvantaged, and implement strategies of information dissemination and awareness raising for these groups.

EAST TIMORESE

The East Timorese are quite clearly a highly vulnerable group. They have been forced into leaving their home country by a prolonged, highly traumatic conflict and found the culture and customs of their new home extremely different to those with which they were familiar. Both have

these have led to what seem to be high rates of mental ill health within the East Timorese community as a whole. Yet the stigma attached to mental illness within the community, along with the fear of 'gossip', prevents many from seeking help for the problems they are experiencing. This is compounded by a relatively low level of understanding of mental health issues generally, which leads many of them to be unable to connect their traumatic experiences with their current situation, or to identify what might be the signs of mental illness.

These issues have been compounded by the unfamiliarity of many East Timorese with the system of social service provision generally in Australia. This leads them to be less likely to access professional counselling services, especially those available at no charge through government-funded programs.

A further complicating factor is that many in the East Timorese community are classified as 'onshore asylum seekers', who are broadly speaking ineligible for government services. There is no information given to people who arrive in Australia through this process.

Due to the enormous differences in dominant East Timorese and Australian cultural mores, it seems that inter-generational conflict is a particularly significant problem within the East Timorese community. This needs to be addressed as a priority for this community to redress high levels of intra-familial conflict and family breakdown reported by the interviewees, as well as to limit the degree to which the mental health issues of first generation East Timorese Australians are transmitted to the second generation.

AFGHAN

Any service wishing to serve female Afghans must overcome multiple barriers. The female interviewer had great difficulty in locating female

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Afghans who were willing to be interviewed for this project. Many initially agreed, but later changed their minds, begging her to understand their situation. It seems that the majority were fearful of their husband's reaction, and did not want to be seen to be 'telling tales' about their family life, their husband's behaviour, and so on, to outsiders. Both interviewers raised situations where men had brought underage girls - some as young as 14 - into Australia as their wives, after having obtained false documents for them. One interviewer expressed concern that this could happen in Australia. Their age, lack of education and dependent situation totally disempowers these girls, leaving them at the mercy of their husbands.

Organisations attempting to provide services to Afghan women must understand their sensitive situation. It should be noted that employing an Afghan woman, as this study did, was not sufficient to overcome this. Undoubtedly, any initiative will have to involve the men of the community, as in many families they continue to exert considerable power.

While the Afghan people interviewed felt that the mentally ill were generally negatively labelled by other Afghans, most of the interviewees agreed that anyone, whether migrant or not, would see their problems as a result of their circumstances and thus be understanding.

However Afghan people are not aware of the range of services available in Australia which could assist them with their problems, and do not know how to get access to this information. When they make first contact with some form of health service, generally a GP, they are not made aware of or referred to psychological services which could assist them, but instead are often treated only for their physical complaints.

PORTUGUESE-SPEAKING

While the majority of the Portuguese-speaking people interviewed chose to come to Australia, it seems that they brought with them expectations about life here that have frequently not been fulfilled. The interviewer felt that this had a significant impact on the mental well being of these people, which the provision of an integrated program of support services following arrival could help to avoid.

The cultural role assigned to wives and mothers as primary care givers emerged strongly through interviews. This often led to situations where uninformed, uneducated women became the primary care givers for a person with a serious mental health problem, receiving little support from either other family members or service providers, of which they were generally unaware.

Domestic violence was identified as a common result, as the coping mechanisms of women are worn down in the face of these difficulties. In many instances this results in the mother developing depression or another form of mental illness when originally she was healthy. Women's passive acceptance of any help offered in this situation also emerged in interviews, which calls into question the degree to which they are making informed consent to treatment.

POLISH

The mental problems of the Polish interviewees were extensive, complicated and chronic.

A major contributing factor seems to be the failure of many Polish people to fulfill the high aspirations they had for their futures in Australia.

Family members and other ethnic community members, rather than being seen as a source of support as they were in other groups, were seen

primarily as a cause of and aggravating factor in individuals' illnesses. This is reflected in high rates of marriage breakdown among this group as a whole, as well as the emergence of significant mental problems among second generation Polish people born here to these dysfunctional families.

Above all, it seems the length of time that Polish people interviewed have been living with their problems, without any or appropriate assistance, which has led to the complexity and chronicity of the issues that are now facing them.

SUMMARY

This project was special in a number of ways. Firstly, it gave voice to individuals and groups who do not appear in statistical reports and rarely have their views incorporated in health service planning. Secondly, it is the result of a sound partnership between public mental health services and community organisations. It is a signal that intersectoral planning can achieve great things. Thirdly, it was the first time that the needs assessment model developed as a national initiative through the ATMHN was used in a local applied setting. The qualitative nature of this research is felt to be its greatest strength, as well as its most significant departure from other research.

The National Mental Health Policy acknowledges that culturally and linguistically diverse people have special needs that should be recognised in the planning and delivery of mental health services. The rich detail of this research highlights the powerful barriers - such as language, lack of information and cultural perceptions - faced by culturally and linguistically diverse communities in understanding mental health and illness, and accessing mental health services. ■

Events Calendar

November

- 10** **Managing Problems Behaviours in People with Intellectual Disabilities and Autism Spectrum Disorders**
Fourth National Conference
Centre for Developmental Disability Studies
The University of Sydney
Tel: 02 8878 0500
Email: hmoore@med.usyd.edu.au
- 13** **Planned Activity Groups - Best Practice Models in Servicing Culturally and Linguistically Diverse Communities**
Australian-Polish Community Services

Maribymong City Council Footscray
Melbourne
Tel: 03 9689 9170
Email: yolas@vicnet.net.au

- 17-18** **Promoting Multicultural Health & Well-being**
First Forum of the SA Transcultural Mental Health Network
Adelaide Congress Centre
Adelaide
Tel: 08 8200 3900

- 21** **Drugs and Other Issues**
Department of Adolescent Medicine,
New Children's Hospital,
Westmead Sydney
Tel: 02 9845 3338

- 30 - 2 Dec** **Education and Social Action**
The Centre for Popular Education
University of Technology, Sydney
Tel: 02 9514 3843
Email: cpe@uts.edu.au

2001

March

- 4-7** **Good Health - Good Country**
6th National Rural Health Conference
National Convention Centre Canberra
Tel: 02 6285 4660
Fax: 02 6285 4670
Email: conference@ruralhealth.org.au

- 28-31** **4th National Conference Infant Child & Adolescent Mental Health**
Australian Infant, Child, Adolescent and Family Mental Health Association
Carlton Crest Hotel, Brisbane
Tel: 07 3858 5563

May

- 28-30** **Diversity in Health: Sharing Global Perspectives:**
2nd ATMHN Conference
3rd Australian Mental Health Conference
6th NSW TMHC Conference
Darling Harbour, Sydney
Conference Secretariat
Tel: 02 9518 9580
Email: diversity@pharmaevents.com.au

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SPRING 2000

Synergy is a quarterly newsletter published by the Australian Transcultural Mental Health Network.

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Australian Capital Territory

ACT Transcultural Mental Health Network (02) 6207 1066
Health Outcomes, Policy & Planning, Department of Health & Community Care (02) 6205 0877

Commonwealth

Department of Health & Aged Care, Mental Health Branch (02) 6289 7722

Community / Consumer / Carer Associations

Australian Mental Health Consumers Network (07) 3394 4852
Carers Association of Australia Inc (02) 6288 4877
Federation of Ethnic Communities Councils of Australia Inc. (02) 6282 5755
Mental Health Council of Australia Inc. (02) 6285 3100
National Ethnic Disability Alliance (02) 6290 2061
National Forum of Services for Survivors of Torture and Trauma (02) 9794 1900

New South Wales

Mental Health Branch, NSW Department of Health (02) 9391 9299
NSW Transcultural Mental Health Centre (02) 9840 3800

Northern Territory

Mental Health, Aged & Disability Services, Territory Health Services (08) 8999 2916

Queensland

Mental Health Unit, Queensland Health (07) 3234 0674
QLD Transcultural Mental Health Centre (07) 3240 2833

South Australia

Mental Health Unit, SA Department of Human Services (08) 8226 6275
SA Transcultural Mental Health Network (08) 8222 5141

Tasmania

Mental Health Program, Department of Health & Human Services (03) 6233 4750

Victoria

Aged, Community & Mental Health, Department of Human Services (03) 9616 8123
Victorian Transcultural Psychiatry Unit (03) 9417 4300

Western Australia

Mental Health Division, Health Department of Western Australia (08) 9222 4099
WA Transcultural Psychiatry Program (08) 9224 1760

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**national
mental
health
strategy**

PROMOTION
PREVENTION
EDUCATION

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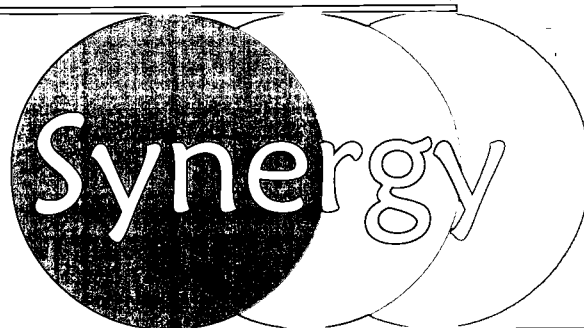
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Summer 2000

The SA Transcultural Mental Health Network Forum: PROMOTING MULTICULTURAL HEALTH AND WELLBEING

On the 17th and 18th of November, 2000 the SA NESBWEB Network held its first forum in Adelaide. Over the one and half days approximately 170 delegates attended, these included interstate visitors, local service providers, policy makers, educators, managers and community members.

A highlight of the forum was the number of community members who attended and participated in the concurrent sessions. The planning committee responsible for organising the event had made a special effort to encourage community members to participate which in turn created an informal and relaxed atmosphere that made this forum different to others. A number of delegates commented on the positive energy and enthusiasm that existed throughout the forum.

The invited Guest Speakers for the forum included Mr. Roger Lean representing the Office of Multicultural and International Affairs (S.A), the Honourable Trish Draper, Emeritus Professor Beverley Raphael, and Professor Harry Minas. A panel was also held to discuss the area of transcultural mental health in South Australia with reference to developments on a national level that will contribute knowledge, resources and working links to SA.

On Friday afternoon Dr Nicholas Procter, and the project team of community educators presented on the successful outcomes to date of the "Reciprocity in Education Project". Many of the community members participating in the project attended the forum that demonstrated their commitment and support to the project. The Project brief is the result of work undertaken by NESBWEB: The South Australian Transcultural Mental Health Network. The presentation by the project team was a perfect ending to the first day of the forum culminating to a celebration at Tandanya, Aboriginal Cultural Institute of the

Networks official launch and the achievements of the Network over the last two years in South Australia.

NESBWEB Network members would like to extend their gratitude and appreciation to the ATMHN and the Department of Human Services (S.A) for funding this event. Also thanks to the Network members who coordinated the Forum and finally to all the community members and other delegates who contributed to the success of the Networks first Forum.



The Hon. Trish Draper, Emeritus
Professor Beverley Raphael, Mr Roger
Lean,



Reciprocity in Education Project Session



Teen novels dominated by gloom and doom

A study of 94 novels chosen as 'notable' by the Children's Book Council of Australia finds that humour is rare, and devastating loss is the norm.

Two-thirds of the books had references to psychiatry but only a minority of characters benefited from seeking professional help, researchers found. Dr Gary Walter, Acting Director of Child & Adolescent Mental Health Services for the Central Sydney Area Health Service and colleagues studied 269 characters in the books, finding 64% experienced a severe stressor such as rape, sustained physical abuse, a life threatening road accident or becoming a refugee from war. Seventy eight per cent suffered a major loss such as death in the family or of a close friend, they reported in the Medical Journal of Australia. About 180 characters were distressed or had psychiatric symptoms, 26 had suicidal thoughts and 10 killed themselves.

The researchers found that the books did not necessarily reflect reality. The rate of family separation in the books was about twice that in the community, and 41 per cent of teenage characters had mental health problems compared with 13.4 per cent in reality.

"We may well ponder whether the genre has crossed the threshold from realism into nihilism," the researchers wrote.

"On the one hand, acknowledging mental illness, understanding it and removing stigma and prejudice is positive, but we argue that perhaps the books have gone too far," Dr Walter said.

Sydney Morning Herald December 11 2000

MENTAL FITNESS

Another reason to get off the couch: researchers at Duke University Medical Center have shown that moderate aerobic exercise three times a week works as well as Zoloft in lifting clinical depression.

What's more, after 10 months only 8% of the exercisers had relapsed into depression, in contrast to 38% of patients on medication and 31% of those who were both exercising and taking medication.

TIME October 9 2000

SMOKING BLUES

Contrary to previous studies, new data suggest that cigarette smoking may lead to teenage depression - not the reverse. In a yearlong study, researchers found that adolescents who smoked cigarettes were nearly four times as likely to develop depression as their non-smoking counterparts.

TIME October 9 2000

Adult schizophrenia drugs used to calm children

Powerful drugs recommended for use only in schizophrenic adults are being prescribed widely for Australian children as young as four, new figures show. Schizophrenia is virtually unheard of in such young children and the revelation has raised fears of falsified diagnosis so that patients can receive the anti-psychotic drugs.

As well, the calming medications may be masking learning difficulties or abuse of the child, says Dr Jon Jureidini, head of the department of psychological medicine at the Women's and Children's Hospital in Adelaide. Dr Jureidini disclosed the high prescription rate among children in a letter to the Medical Journal of Australia published in November.

Nearly 3 000 Health Insurance Commission approvals, each for six months' supply of the drugs, were granted in the year to May, he wrote. At least 1 500 children under 13 had taken either risperidone or olanzapine, a quarter of them under nine. In NSW, the prescription rate for children aged nine to 12 was 60 per cent above the national average - with 33 approvals for every 10,000 children in the State.

But pediatricians and child psychiatrists criticised his conclusions, saying they did nothing to help children with extreme behavioural difficulties. "I have no qualms about using risperidone," says Dr Don Butler, a Sydney pediatrician. "If it was cheaper and didn't have this stigma I'd use it a lot more. These are children expelled from school, in homes or respite care, children with mental retardation or autism."

A Sydney child psychiatrist who did not want to be named said he used very low doses of risperidone, which was "very, very useful for conduct disorder.....You get a window of opportunity to do remedial work with these children".

The president of the pediatrics division of the Royal Australian College of Physicians, Dr Jill Sewell, said it was not unusual for doctors to prescribe drugs which had no specific recommendation for children. This was because drug companies avoided testing drugs on children. Dr Sewell said she was surveying the prescriptions for children in order to develop national guidelines.

Sydney Morning Herald November 20 2000

Getting in the Way of Effective Mental Health Promotion, Prevention and Education OR A Not So Funny Thing Happened on the Way to the Forum

By Carlos Suárez

Consumer Project Officer, NSW Transcultural Mental Health Centre

I want to tell you a little story about 'what happened on my way to the forum', except that I took this journey as a consumer and the beginning of that journey was no laughing matter.

The first half of my story shows how unacknowledged and internalised stigma can get in the way of the actual people who devise mental health promotion, prevention and education programs in developing effective strategies. The second half is about practical strategies that I suggested at such a forum.

I was recently invited to participate at a forum with the Student Counselling team and the Academic Liaison Officers of a major metropolitan university putting together an action plan to deal with student mental health issues. The basis of my invitation was that I am a university student living with a mental illness and the strategies I suggested led to my being asked to return as a consultant on future mental health education and promotion strategies.

The dynamics of the forum were actually quite an eye opener into the realities we all face with stigma and the way it gets in the way of proper mental health promotion, prevention and education. For example, I was asked to participate on the condition that I was not a student of the university. As I am a student of that university I asked why. When I was told in vague terms that they "didn't want to blur the boundaries", I was initially confused but soon began to smell the 'stigma rat' from a hundred miles away.

"Blur which boundaries?", I asked ever so innocently. "Um, the boundaries between you and staff" replied the polite gentleman, ever so uncomfortably. Hmmm. "So, would this be issue if I were a student with epilepsy?" We were now entering the 'stigma vortex' where people (usually the stigmatisers) get catapulted into uncomfortable orbits.

When I arrived at the University forum I was introduced to another staff member who then introduced me to another person as "This is Carlos Suárez. He's the student coming to talk about [voice drops to a whisper and eyes dart away] his mental illness."

Now, here we had a group of well meaning professionals coming together with the very best of intentions to tackle 'The Mental Health Dilemma' and as I pointed out to them in the first minutes, we had all just witnessed two examples of stigma before the forum had even started! The significant difference being that they merely had to witness it like onlookers at a roadside accident, whereas I had to feel the full body blow to my guts. But hey, Carlos, get over it. After all, you're just, well, a... 'consumer'. It is a particularly warped and sad reflection of our society that out of propriety, I am expected to leave the said university nameless yet I have to feel that blow.

Continued Overleaf

Synergy Summer 2000

Squirming in their seats, the participants realised only too painfully that they had not started out on what one would call a politically correct note. And you know what? **IT WAS THE BEST THING THAT COULD HAVE HAPPENDED.** People opened up and really got down to the nitty gritty of things because the stigma phantom had been brought out of the shadows on an experiential, not intellectual level. The co-ordinator said he had never seen such a fruitful and productive flow of ideas.

Which brings me to how I came to be asked to return as a consultant. I suggested that the greatest problem with mental health promotion is the expression 'mental health' itself. While it may be convenient shorthand for mental health professionals, I feel it alienates people in the wider community ie. The people you are actually meant to be helping.

Thus, instead of promoting something like an official "Mental Health Awareness week" at the university, my suggestion was that they move towards a 'Chill Out' theme which is student-speak for "Stress Less". What if, I asked daringly, the main university hall were to be filled with rows of massage tables manned by final year students from the Traditional Chinese Medicine degree who would give free 10 minutes massages that could count towards their clinical experience quota? Why not throw in a 'showbag' which would include such treats as sherbet bombs, movie discounts and information checklists along the lines of "Are you feeling crabby a lot lately, can't sleep, lost your appetite, not enjoying the things you used to, etc?" Then come up for a free confidential chat at Student Counselling.

This technique doesn't once mention that the person might either have an 'illness', a 'mental illness' or worse still, strike fear in the student that he may be 'mad', 'bad' or 'crazy'. Yet it gets the student to the service provider via the backdoor. With a few lollies in his showbag to boot!

My fear that the idea might be considered somewhat left-of-field was dispelled by being invited back as a consultant on mental health promotion.

In last year's NESB Mental Health Forum sponsored by the NSW TMHC, I read somewhere that a successful promotional technique for older NESB men was to hold a forum, not on 'mental health', but on fishing of all things. There they could introduce 'life style issues' which naturally led on to 'stress management' which then led to 'signs that might show you are depressed'. Suddenly, you were educating older NESB men about 'mental health' – surely an impossible exercise! It was savvy marketing to hook them in with fishing because fishing is a relaxing activity. The peace one experiences while fishing on a lake in the company of mates and a few cold beers interlocks snugly with what mental health promotion is ultimately aiming at – inner peace.

Similarly, a recent successful public forum with the Croatian community was promoted something along the lines of "How to Deal with Life's Problems". Have you ever wondered why forums that are advertised as "Looking After Your Mental Health" hardly attract anyone? The medicalisation of emotional distress is one thing. The medicalisation of public relations strategies is quite another.

People out there are in desperate need of information. Yet they will not access it if it is couched in terms of 'mental illness', which raises the image in popular culture of the 'mad psychiatrist' with uncontrollable grey hair in a white lab coat. When someone is living in extreme distress on the abyss between sanity and insanity (don't worry, it's OK, I'm allowed to use that word), they don't say to themselves "I think I am experiencing a mental illness." They think, "My God, I'm losing it".

It was the famous North American psychiatrist Harry Stack Sullivan who said he treated people who had "difficulties in living", not a "mental illness". It is no surprise to me that he was both highly esteemed as an extraordinary clinician and that he lived with his own mental illness, which (surprise surprise) didn't do his reputation much good in the eye of his colleagues. While it may be valuable in some cases to medicalise people's "difficulties with living" into a "mental illness" from a clinical point of view, it is absurd to use the same approach for promotion, prevention and education.

Just ask anyone who has worked in an advertising agency for 72 days. □

Prior to becoming the Consumer Project Officer at the NSW Transcultural Mental Health Centre, Carlos won a graduate traineeship with a multinational advertising agency under the auspices of the Advertising Federation of Australia. He experienced his first psychosis while at the agency and wishes to make it abundantly clear that working in advertising and the onset of psychosis were in no way related.

Visit the ATMHN Website
www.atmhn.unimelb.edu.au

Development of Transcultural Mental Health Education by the Victorian Transcultural Psychiatry Unit

Diane Gabb

Coordinator, Education & Professional Development

Victorian Transcultural Psychiatry Unit

There is a long history of interest in transcultural mental health in Victoria, with the work of Jerzy Krupinski and his group at the Mental Health Research Institute from the 1960s on the mental health of immigrants, and Ivor Jones and others from the 1970s on the mental health of Aboriginal communities. In 1983 Harry Minas had published in the Medical Journal of Australia the results of a study examining the relative rates of use of ECT in the treatment of Australian-born and immigrant patients. A number of such studies demonstrated that there was considerable variation in the prevalence of mental disorders in different immigrant groups, and that there were substantial problems in the diagnosis and treatment of mental disorders in patients of immigrant background.

The international epidemiological work done by Norman Sartorius, Assen Jablensky and their colleagues at WHO and the anthropologically informed work of Arthur Kleinman had a substantial influence on the development of transcultural psychiatry in Australia. The Italian movement of de-institutionalisation and attention to the rights of people with mental illness, known as *Psichiatria Democratica*, found expression in Australia with establishment in 1983 of the first specialised Australian transcultural mental health centre in Perth by Gianfranco Boranga and his colleagues. This pioneering centre was joined in 1989 by the Victorian Transcultural Psychiatry Unit (VTPU) and subsequently by the Transcultural Mental Health Centre in New South Wales and the Queensland Transcultural Mental Health Centre.

The VTPU commenced developing its program of work at the Royal Park Psychiatric Hospital but very soon moved out of the hospital to a community setting - a delightful terrace house in Fitzroy. Although the main emphasis in the beginning was direct clinical services in the language of the patients referred to the Unit (four psychiatrists - from Italy, Turkey, Yugoslavia and Vietnam - who had been recruited by the then Office of Psychiatric Services joined the staff of the Unit), the proposal to establish the VTPU emphasised the need to integrate clinical work with a program of work in the areas of policy and service innovation, research and education. The key issue was the development of a comprehensive and integrated capacity to respond to cultural and linguistic diversity. It was recognised at the beginning that research and education would underpin developments in policy and clinical practice.

EARLY EDUCATION INITIATIVES

The VTPU has contributed to psychiatric registrars' training, and undergraduate and postgraduate medical courses on a regular basis since the inception of the Unit. Most regular postgraduate teaching was incorporated into the subject of Social Psychiatry within the Master of Psychological Medicine degree. During the early 90's a series of lectures on transcultural topics was delivered to mental health professionals on an informal basis. This program was to become the forerunner to the formal award course developed in late 1995 and delivered from 1996 to the present as a Graduate Diploma of Mental Health Sciences (Transcultural Mental Health), under the imprimatur of the University of Melbourne and taught within the Department of Psychiatry.

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These early beginnings laid the foundation for a growth in program development and delivery which currently reaches beyond the medical profession to a range of health and welfare practitioners including those in psychology, counselling, occupational therapy, psychiatric disability support and employment, psychiatric nursing, health administration, physiotherapy, education and student support.

PROFESSIONAL DEVELOPMENT BRIEF

Currently the VTPU is required to design and deliver professional development in the form of short training sessions for area mental health staff. These are usually for a minimum of three hours in duration, but are often designed for a whole day's input, or on rare occasions, a two-day program. Mostly they are delivered on site so that attendance of as many people as possible is made easy. What began as a requirement to deliver a total of seven full days over a whole year has increased to a capacity amount of eighty full days a year. This of course has required a changed strategy which includes producing a timetable of available blocks for teaching sessions made available to AMHS managers for bookings early in each year.

TOPIC SCOPE

The scope of transcultural mental health topics has increased over time to reflect the varying needs and perspectives of area mental health services across adult, elderly, child and adolescent focuses. Topics range from the more general and abstract like the relationship of culture and mental health, culturally sensitive practice, cultural and religious values systems, migration, and explanatory models of illness to the more specialised which pay attention to matters of gender, age, cross-cultural communication, counselling, child rearing practices, carer and consumer perspectives, and working with interpreters. Some of the

most recently developed topics include the cultural construction of sexuality, second generation mental health, the welfare and mental health of international students, holocaust survivors and ageing, and vicarious traumatisation of staff.

Topics are developed after conducting a needs analysis on a particular area mental health service or agency and the relevant catchment population. This process then is followed by careful attention to the evaluation received from participants after each session which assists in the refinement and development of further programs on similar topics and for similar or different audiences. Topics are available as discrete subject modules to be assembled in varying configurations to best suit each audience.

COLLABORATION ON INDIGENOUS MENTAL HEALTH EDUCATION

As the cultural diversity of all minority groups within the Australian population is vital in an inclusive transcultural understanding of mental health and illness, the VTPU has responded to requests from practitioners to include indigenous mental health issues within the programs. These sections have been developed and delivered in close collaboration with the Resource Unit for Indigenous Mental Health, Education and Research (RUIMHER), under the auspices of the University of Melbourne. Participant response has been very positive as many report that their professional education about issues affecting their indigenous clientele has been largely non-existent. A model for a combined indigenous and non-indigenous delivery of training programs resulting from this part of the program has attracted considerable attention nationally and internationally. It is also seen as a practical contribution to reconciliation activity under the health and welfare umbrella.

THE 'AWARENESS, KNOWLEDGE AND SKILLS' MODEL

Paul Pedersen's model developed in USA in 1994 as a response to the need for multicultural training of counsellors has been very effectively used in Victorian AMHS settings. The model is based on a combination of affective and cognitive learning strategies which may lead to attitudinal change as well as knowledge and skill acquisition. Practitioners need to understand the nature of the basic building blocks of the transcultural paradigm, firstly the awareness that

healer and patient, practitioner and client, are part of the same equation in that the cultural values of both parties are an integral part of understanding the interaction and relationship to best advantage.

This is essentially a different approach to traditional medical teaching where the practitioner's cultural perspectives are not a focus or part of the teaching content. For many practitioners, this focus is a new and challenging one to grasp, but once explored and connected to their own fields of work, it develops meaning and legitimacy.

This is followed by knowledge about significant details or events important in minority group history and experience, e.g. refugee and indigenous experience of displacement and loss, major world events that have caused people to migrate or flee their country of origin, or the range of causes - natural, psychological and supernatural - to which people attribute illness. Participants are alerted to expect the experience of an on-going learning curve that will help them to accumulate relevant cultural knowledge from their clients during the course of their active professional practice, and to be comfortable with the ad hoc nature of this type of knowledge acquisition.

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ATMHN re-elected to MHCA Board

At the recent Mental Health Council of Australia Annual General Meeting, the ATMHN was re-elected to the Board of the MHCA in the "special needs" category. Congratulations to ATMHN Advisory Group representative, Associate Professor Harry Minas, who was re-elected to the Executive of the MHCA and to the position of Chairman, Research, Policy and Projects Sub-Committee of the Board.

'DIVERSITY IN HEALTH'

Registrations for "Diversity in Health" are now open. The registration brochure is in this edition of Synergy, however, if you failed to receive a brochure, contact the Conference Secretariat on 61 2 9518 9580 or check the Conference web site at www.tmhc.nsw.gov.au/diversity.htm.

The ATMHN is proud to report an overwhelming response to the call for papers for "Diversity in Health", with over 300 abstracts submitted for oral, workshop and poster presentations. Successful authors will be notified early in 2001. Thanks also to the many people who worked on developing the conference program and gave generously of their time to ensure that delegates will hear work of the highest quality.

Adelaide Forum

The ATMHN Management Unit also travelled to South Australia in November 2000 for "Promoting Multicultural Health and Well-being", the first SA NESBWEB Forum, sponsored by the ATMHN. Congratulations to all members of SA NESBWEB for organising an excellent program of guest speakers and concurrent papers! The final ATMHN Advisory Group Meeting was also held in Adelaide in conjunction with the Forum.

FECCA CONFERENCE

Survey of Health Promotion Resources

Does your organisation have mental health promotion resources (pamphlets, tapes, videos, web sites etc) in community languages? The ATMHN Management Unit is conducting a survey of multilingual mental health promotion resources around Australia, to assist in developing a range of mental health information. The last edition of Synergy included a fax or mail back survey so readers could let us know of their resources. Thank you to all those who responded!

If you have resources which you think the ATMHN may not know about please call (02) 9840 3333 and we will fax you the survey questionnaire.

FECCA Conference, WA

November 2000 saw the ATMHN represented at the Federation of Ethnic Communities Councils of Australia (FECCA) Conference in Fremantle, WA. Sandee Baldwin, ATMHN Media and Communications, presented a very successful pre-conference workshop on using the media and developing a media kit, and offered delegates information on the ATMHN and its member organisations at our information stall. Thanks to representatives of member organisations attending the FECCA conference for their assistance with the stall.

THANKS!

On a personal note, I would like to thank Sandee Baldwin and Scarlett Vinals, the staff of the ATMHN Management Unit, for their contributions to the Unit during 2000. Last year was particularly busy, with many new projects and challenges, as well as the day to day operations of the Network. In preparing for "Diversity in Health" the Management Unit has been fortunate to have Tanya Zenari join us from NSW TMHC to undertake the huge task of coordinating work on the Conference Program, in conjunction with our Conference Organisers, Pharma Events. Thank you all for your hard work, exceptional commitment and unfailing good humour.

How do ethnic communities perceive mental health, illness & services?

Forum proceedings. This forum was a collaborative project organised by the Darebin Ethnic Communities Council, mental health services and other community agencies to provide an opportunity to hear from Ethnic Communities regarding mental health.

Darebin Ethnic Communities Council October 1999

Aboriginal mental health and illness perspectives: The lived experiences of a group of Koori are in Ballarat, Victoria

This study, a result of a Masters Thesis, explores how Koorie people living in the Ballarat region of Victoria perceive mental health and illness. The reasons why Koories felt that health care services, including mental health care agencies, were culturally inappropriate were identified in the study.

Sue Turale Ballarat, 1992

Needs of frail elderly NESB migrants and their carers in the Eastern Metropolitan Region.

A pilot project carried out by the Communities Council on Ethnic issues which examines the needs of frail aged culturally and linguistically diverse migrants and their carers in Monash and Boroondara.

January 2000 Victoria

The following publications are as a result of the World Health Organisation's new initiative to deal with the increasing burdens of mental health and substance abuse worldwide.

Lexicon of psychiatric and mental health terms Geneva, World Health Organisation, 1994.

This publication is designed as a companion volume to the ICD-10 classification of mental and behavioural disorders.

Gender differences in the epidemiology of affective disorders and schizophrenia.

Geneva, World Health Organisation 1997.

The mental health of indigenous peoples: an international overview.

Geneva, World Health Organisation 1999

A focus on women

Geneva, World Health Organisation 1999.

Health futures: a handbook for health professionals

Martha Garrett

Geneva, World Health Organisation, 1999.

Community emergency preparedness: a manual for managers and policy-makers,

Geneva, World Health Organisation, 1999 .

A landmark conference on multicultural health and well-being



Diversity in Health
Sharing global perspectives

28-30 May 2001

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www.tmhc.nsw.gov.au/diversity.htm

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NSW+HEALTH

Incorporating

Australian Transcultural
Mental Health Network
2nd National Conference

3rd Australian Multicultural
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NSW Transcultural
Mental Health Centre
6th Conference

A Better State of Mental Health For All: Effects of a Multilingual Multi-Media Community Awareness Campaign

John Spiteri, Maria Cassaniti
NSW Transcultural Mental Health Centre

It is acknowledged that the burden of mental health problems is large and increasing. Eighteen percent of people aged over 18 years in Australia reported the experience of a mental health problem or disorder (anxiety, affective or substance use disorders) in the past 12 months. Prevalence is highest for young people aged 18 to 25 years (27 per cent). Despite this, only a small percentage of people with mental disorders actually seek help (38 per cent) (Andrews, Hall, Teeson & Henderson, 1999 cited in Pope, Scanlon, Raphael, Heslep, Cassaniti & Spiteri, 2000).

Further, recent research highlights that communities of NESB have a lower use of mental health services. While these communities may be less inclined to use mental health services, the prevalence of mental health problems may not be less (McDonald & Steel, 1997). The lower use of mental health services may be an indication that children and adolescents of NESB are also a high-risk group unlikely to be engaged by early intervention strategies targeting the mainstream community. Minas, Lambert, Kostov and Boranga (1996) listed the following reasons for the lower use of mental health services by communities of NESB:

- Lack of information about available services.
- Reduced access to services due to language and cultural barriers.
- A greater stigma attached to mental illness and the treatment of mental illness by some communities; and
- In some cultures, individuals tend to somaticise their psychological problems.

The authors go on to suggest that the consequences of underuse and reduced access to appropriate treatment are:

- Substantial numbers of people from NESB whose mental health problems are unrecognised and untreated; and
- Poorer treatment outcomes for those who do receive treatment.

This highlights the importance of improving mental health literacy among NSW's culturally diverse population and establishing initiatives to promote the mental health and prevent the onset of mental health problems and disorders (Jorm, Korte, Jacomb, Christensen, Rogers & Pollit 1997; Haggerty Mrazek & Haggerty, 1994; Marshall & Watt, 1999 cited in Pope et al, 2000).

New South Wales has one of the most culturally diverse populations in the world. The State is home to 40 per cent of Australia's non-English speaking background (NESB) overseas-born population (Australian Bureau of Statistics, 1996). In 1996, 27 per cent of the NSW population were born overseas, in a non-English speaking country. This equals a total of 1, 015, 862 people aged 5 and over who reported speaking a language other than English at home (Australian Bureau of Statistics, 1996). Children, adolescents and their families from culturally and linguistically diverse backgrounds may be at risk for poor mental healthoutcomes due to a wide range of factors.

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These include:

- Migration or refugee experiences.
- Intergenerational conflict.
- Grief and loss relating to the migration experience, as well as separation from family members.
- Post traumatic stress from experiences prior to resettlement, difficulties with acculturation.
- Possible experiences of racism and discrimination after resettlement.
- Marginalisation.
- Educational disadvantage.

In 1999, to help families from culturally and linguistically diverse backgrounds better understand and recognise mental health problems in children, adolescents and young people, as well as to encourage families to seek help early. The NSW Department of Health in partnership with the NSW Transcultural Mental Health Centre (TMHC) and SBS Radio embarked upon a broad based multi-level public awareness campaign to produce the Multilingual Family Help Kit (the Kit) targeting fifteen language groups.

The Kit differs from the original FHK in a number of ways it includes additional material to cater for people from culturally and linguistically diverse communities special needs. The additional material covered in the Kit includes issues surrounding:

- Financial hardship (sometimes due to the inability to find employment).
- Inability to speak English or to communicate with others, that may in turn effect their educational performance.
- The lack of social networks, or religious activities and the lack of support from family and friends.
- The possible exclusion from health and other services, particularly for refugees.
- The age that the child, adolescent or young person migrated.
- Difficulties in accessing health and other social services, particularly for refugees.

- Experience of trauma or prolonged stress in one's home country, especially in the case of survivors of war and torture.
- Difficulties at school.
- Problems that relate to experiences of parents in their home country that may inadvertently effect their son and daughter.
- Challenges in attempting to balance the Australian way of life with the need to preserve traditional cultures and values.

In addition to the printed booklets, the Kit comprises of audio cassettes and have been placed on the TMHC Web page. Additional partnerships were also formed with bilingual/bicultural health professionals, community workers, multicultural community welfare agencies, ethnic community organisations and key community members, including young people, who were consulted to ensure the information and issues covered in the Kit were sensitive to the cultures, values and practices of the targeted communities and language groups.

Parents from culturally diverse backgrounds have a wide range of mental health education needs regarding children and adolescents. Parents from culturally diverse backgrounds need to be supported in understanding child and adolescent mental health issues in the context of their own culture and language, as well as in the context of the wider communities in which they live.

The Kit focuses on building bridges between families from culturally diverse backgrounds with the NSW health system and other related support services. The overall goal of the community awareness campaign is to promote the mental health of children, adolescents and young people of targeted culturally and linguistically diverse communities. This was achieved by educating parents about mental health problems that children, adolescents and young people may face and on identifying early signs and

symptoms. The Kit also challenges attitudes to mental illness and aims to reduce stigma associated with mental illness amongst the targeted communities.

The Kit provides information on the following topics:

- Child and adolescent mental health problems;
- Prevention of suicide;
- Challenging behaviours;
- Psychosis;
- Body image and eating disorders;
- Post traumatic stress;
- Depression;
- Fears and anxiety;

The Kit presents mental health issues as they are understood within western medical science paradigms, while reflecting social, cultural, linguistic and religious values and practices of the targeted communities. The Kit also discusses issues that may present in families who have migrated to Australia. As a result it promotes the importance of cultural diversity and offers families the framework for support within the wider community. The Kit also discusses the additional mental health issues that children and adolescents of culturally diverse backgrounds may face such as racism, culture and language barriers.

This project has added to current knowledge of effective strategies to promote mental health literacy within culturally diverse populations. There is limited literature on processes undertaken in promoting mental health literacy across a range of culturally diverse populations. To date the majority of mental health literacy campaigns in Australia have focussed on the mainstream population. Wide-scale education campaigns have often overlooked the needs of individuals and families from culturally diverse backgrounds. Therefore, the development of well documented evidenced-based strategies for communicating mental health issues have remained quite limited. Makara (1997) argues:

"that currently used tools of health promotion and primary prevention can at best only achieve solid results among the middle and upper-middle classes of society. This also means that effective health promotion is likely to contribute to the increase of social inequalities in health. The old health education and prevention dogmas are often useless among the poor, ethnic minorities, the unemployed and immigrants"

This project has not only provided opportunity to explore processes that contribute to building positive mental health for culturally diverse populations both within particular communities and networks and across a range of communities but results of the findings subsequent to the intervention point to the success of the strategy at least in the short term. The project developed a range of formats to promote the mental health of children, adolescents and young people in order to cater for the varying information needs of individuals and

families even within a specific language group.

Further work in the area of educating parents on how to encourage the development of a positive ethnocultural identity along with high self esteem needs to be undertaken. They also need to be educated on strategies which assist parents to retain styles of parenting from the culture of origin, blend parenting skills from the culture of origin with parenting skills from the new culture, as well as develop effective parenting styles which suit the individual family's needs in the Australian context. Such strategies aim to address the needs of children who are exposed to living within a diverse range of cultures. □

For copies of the booklets and cassettes contact Ms Mary Meli, Resource Officer, NSW TMHC on Tel:(02) 9840 3800
The fifteen translated booklets are on the NSW TMHC Website at www.tmhc.nsw.gov.au

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"Underwater Handstand" by Michael Leunig from *Goatperson & Other Tales*, published by Penguin Books

NSW Refugee Health Service

Managing Survivors of Torture and Refugee Trauma: Guidelines for General Practitioners

Increasing numbers of refugees and other humanitarian entrants settling in Australia each year have ensured that health care professionals will be asked to provide social, physical and mental health services for a growing number of refugees from diverse cultural and ethnic backgrounds.

Most refugees have been exposed to traumatic events of varying degrees of severity. These events include enforced dislocation from their homes and community, refugee camp experiences, loss of and separation from family members in violent circumstances, and prolonged exposure to human rights violations. In addition, a significant number would have been subjected to severe physical and/or psychological torture.

As a consequence, on arrival, refugees often have worse health than the Australian-born population. Refugees frequently report poorer health status, higher levels of long term problems and psychological difficulties. There is extensive literature on the psychological consequences of experiencing traumatic life events for refugees. Specific types of trauma are associated with high rates of posttraumatic stress disorder (PTSD), depression, and other psychiatric disorders.

Given the high risk among refugees from exposure to traumatic events, it is likely that GPs will encounter more patients who have experienced refugee trauma. General practitioners are often the first point of contact for refugees seeking assistance from the health care system in Australia. While managing refugee patients requires many skills similar to managing the general patient population,

there are additional skills and information that can enhance the GPs' approach in managing this patient group. GPs themselves perceive that their skills in refugee health are limited. This is due to a number of factors including language and cultural barriers, the time constraint in dealing with these issues in the current general practice setting, and lack of screening programs and support from other primary health care services to a such group of population.

This resource "Guidelines for General Practitioners: Managing Survivors of Torture and Refugee Trauma and accompanying audit tool represent current recommended practice and are intended to provide a flexible guide for GPs in the assessment and management of these patients, subject to the medical practitioner's expert judgement in each individual case. They can also be used as a basis for continuing GP education in this area.

The handbook also contains case studies, which serve as practical examples of the refugee experience and its implications on health and health care.

This publication was produced jointly by STARTTS, the NSW Refugee Health Service, the Centre for Health Equity Training, Research and Evaluation (CHETRE) and the General Practice Unit of South Western Sydney Area Health Service.

Free copies are available from:
NSW Refugee Health Service
Tel: 02 9828 6600
Fax: 02 9828 6601

The Guardianship Tribunal: Seminar for professionals working with CALD communities

The Guardianship Tribunal is a legal tribunal with the power to appoint guardians or financial managers for people 16 years and over who are incapable of making their own decisions because of a disability. The Tribunal can also consent to medical and dental treatments for people incapable of consenting for themselves.

Most people with disabilities do not need a guardian because either they are able to make their own decisions or they have others making those decisions informally. The Tribunal will not appoint a guardian for a person incapable of making their own decisions if appropriate decisions are being made and carried out for their benefit by others.

The Tribunal runs a community education program for professionals and carers. As a new initiative we are

holding a seminar aimed at professionals working with culturally and linguistically diverse communities. The seminar will cover; what the Tribunal does; the relevant legislation; guardianship and financial management; making an application; substitute consent for medical or dental treatment; informal options for decision making; planning ahead.

The location for the next seminar is Corrimal (Illawarra, NSW) on Wednesday 20 June 2001, 10 am - 4 pm. The seminar will cost \$66.00 including GST.

For further inquiries contact:
Sue Young or Di Cracknell on;
Tel: 02 9555 8500
or visit our website at;
<http://www.gt.nsw.gov.au>

FORUM REPORT

How do Ethnic Communities perceive mental health, illness and services?

Jorge Torrico

Ethnic Mental Health Consultant, Northern Area Mental Health Service, Victoria

There are a significant number of research findings and analysis from the cross-cultural perspective in regards to how the migration process affects the mental health of immigrants and refugees. However, there are few opportunities provided to immigrants and leaders of ethnic communities to express their views in regards to mental health, illness and services.

Gaetano Greco, Chairman of the Darebin Ethnic Communities Council, Victoria said, "It is very important to understand the influence of culture and stigma towards mental illness and the risks of developing mental health problems by migrants and refugees. The absence of community supports such as appropriate cultural and community networks can also influence the risks of developing mental health problems. Therefore if services are going to be culturally relevant for the ethnic communities, service providers need to understand these issues. The forum organised last year provided a unique opportunity for mental health service providers to learn about how do ethnic communities perceive mental health, illness and services."

On 21 October 1999, a major forum for ethnic communities was successfully organised. Representatives and leaders of ethnic communities in the Northern Area Mental Health Services, Victoria were asked to have their say, on "How do ethnic communities perceive mental health, illness and services". Jorge Torrico, Ethnic Mental Health Services Consultant for the Northern Area Mental Health Services (NAMHS) and the North East Mental Health Services (NEAMH) Austin and Repatriation Medical Centre coordinated the forum. The forum was auspiced by the Darebin Ethnic Communities Council (DECC) and the following organisations participated in the partnership: The City of Darebin Municipal Health Plan, North East Health Promotion Unit, Women's Health In the North, Darebin Community Health and Neami. A committee with representation from the above organisations was established to oversee the activities leading towards the forum and beyond.

Those who attended the forum included ethnic community leaders, senior managers, clinical staff, community workers and nursing staff. The number of participants on the day indicated that there is a great interest in the topic of this forum. This was the first forum on mental health targeting the ethnic communities in the northern region.

Discussions with DECC indicated that mental health and mental illness were not readily included on their agenda. For this reason it was determined to organise a forum with the ethnic communities during the Mental Health Week as the initial step to promoting their active participation.

The following organisations submitted their interest in speaking on the day: The Greek, Macedonian, Chinese, Vietnamese, and Somali communities. The representatives of the nominated communities then organised focus groups to prepare their papers. This forum was advertised as a means of providing a learning experience for both; the ethnic communities and staff from the area of mental health services and managers who are involved in the implementation of policies and the delivery of mental health services. Understanding how the ethnic communities perceive mental health, illness and services is vital for improving and addressing the mental health needs of ethnic communities especially of newly arrived migrants and refugees.

THE PRESENTATIONS

The morning session comprised of speakers from ethnic and service representatives. The Mayor from the City of Darebin Cr. Chris Kelly welcomed the participants and congratulated the organisations for their involvement in addressing the issues of mental health. The Chief Executive Officer of Neami, Mr. Arthur Papakotsias spoke about the difficulties faced by immigrant communities in navigating through the mental health system. Dr Tim Lambert, Associate Professor and Director of Clinical Services NAMHS, addressed the forum on the topic entitled "Ethnicity and the variables that should not be neglected in the practice of Pharmacology."

WHAT WERE THE VIEWS OF THE ETHNIC COMMUNITIES REGARDING MENTAL HEALTH, ILLNESS AND SERVICES?

Dr On Lien, Psychiatric registrar from the Alfred Hospital represented the Vietnamese community. The Vietnamese

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people believe that the causes of mental illness are grouped in the following causes: supernatural, animistic, magical, and natural causes. Depressive illness is due to karma and fate, whilst psychosis is perceived as the loss of one's soul. The early detection of mental illness and taking into consideration the cultural and religious beliefs of the Vietnamese community by the service providers is important in successful treatment. Community education to minimise stigma will improve access to mental health services and treatment for people suffering mental illness. For the Vietnamese community the acculturation process, English language proficiency especially for the elderly and unemployment remain major hurdles.

Shaza Nur, spoke about the Somali community which is one of the more recent communities to arrive in Australia. Their previous experiences of civil war and subsequent famines have dislocated the Somali community. Shaza elaborated on the differences between the Somalian traditional methods in the treatment of mental illness, as opposed to the western approach of treating mental illness in the clinical and conventional method. The religious Somali beliefs interprets seeing visions as the ability to be in touch with higher spirits, however in the western world this experience may be interpreted as a psychotic experience. The recommendations made by the Somalian group would attempt to address the cultural, religious and linguistic needs of the Somalian community.

Mrs. Amal Diab, from the Arabic community said that "mental health and illness issues are usually accompanied by the stigmas of shame, dishonour and denial within the Arabic speaking community at large, particularly where the educational background is of a low standard. It is even, for many, considered a curse of evil spirits inflicted upon their family. In general, the knowledge available is scarce due to lack of acceptance, denial and avoidance of mental health issues." She said that socio-economic background, education, religion and culture of the afflicted family come into play when deciding at which point to reach out to health service providers. The Arabic community generally would be very reluctant to use mental health services due to the sensitivity of the issue and traditional beliefs in relation to mental illness. There is also a lack of understanding of these factors on the part of mainstream professionals. The Arabic Speaking Community believes that mental health services are not flexible enough to respond with preventative strategies.

Other speakers included Nicholas Lykopandis from the Greek community of Darebin, Dr. Cynthia Fan, Senior Lecturer Department of Psychology at Victorian University and Victor Tsakmakis from the Macedonian community.

Concerns shared by the speakers were around how ethnic communities perceive mental illness. Within the Chinese community, people feel inhibited to speak about mental

illness. However, 'mental health' was related to wellness and to resilient factors to cope with adverse effects in difficult situations of trauma, life hardships and grief. This created a dichotomy of feeling safe to speak about mental health, and feeling inhibited to speak freely about mental illness.

SO WHAT WAS ACHIEVED?

The forum provided an opportunity for ethnic communities to confront the issues of shame and stigma around mental illness and they welcomed the forum in dispelling these issues. It also provided the opportunity for links between ethnic communities, mental health services and other community services to be made. The forum achieved the following:

- ethnic communities to express their views about mental health, illness and services by putting forward their recommendations to improve access to mental health services.
- the increasing of awareness about the role that ethnic communities have a role in lobbying mental health services and government agencies on behalf of their communities.
- Opportunities for the development of partnerships with ethnic communities.
- learning opportunity for all the forum participants.

The participants recommended more of these forums, workshops and follow up activities as a result of their recommendations. The forum enabled the proactive participation and identified opportunities for organisations like DECC to facilitate ethnospecific activities in conjunction with mental health services.

In conclusion, a consumer member of the Ethnic Mental Health Advisory Group NAMHS & NEAMH Mr. Evan Bichara, made the following comment after the forum "The forum organised at this level put mental health as a priority of concern to the participants and particularly the ethnic communities. I feel that by sharing knowledge, a practical approach towards addressing the stigma attached to mental illness is made. This is something I have been working on and I am very pleased to see it happening."

The Ethnic Mental Health Consultant of the NAMHS and NEAMHS in conjunction with DECC has documented the proceedings of the forum. This includes the papers presented during the day as a resource for those wanting to increase their understanding of transcultural mental health. ■

For further information contact;

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SURVEY RESULTS

Warning - caring is a health hazard

Louise Gilmore

Board Member, Carers Association of Australia

It is easy to take carers for granted. What is more natural than for families and friends to look after their own? The rhetoric is that carers take on the job because they want to, from love. In many cases this is true, but the results of a survey conducted by the Carers Association of Australia show that in fact, carers may have few choices and that they pay a considerable price.

The report, released in October, is called Warning - caring is a health hazard. It was compiled from 1449 responses to 15,000 survey questionnaires distributed to carers throughout the country. The survey was a seven-page document aimed at finding out how caring had impacted on carers physical, mental and emotional health and wellbeing. It asked for details of injuries caused by caring, compensation received and what, if any information or training carers had received to help them avoid or minimise injury. It also asked what practical and emotional support they had received, how much of their time they spent providing care and how being a carer had impacted on their life opportunities and choices.

The report shows that while caring for someone can be a positive experience, many carers are being harmed physically, mentally, emotionally and socially by their caring responsibilities, but have few, if any ways to avoid that harm.

The respondents are representative of the wider carer community in terms of gender (71% female) and number of years caring (86% had been caring for between three and more than 10 years), compared with the 1998 ABS survey, Disability, Ageing and Carers: Summary of Findings. However, they are older, more isolated and more often caring for partners than the wider community. This means that younger carers, indigenous carers and carers from a CALD background are under-represented.

Carers were asked to rate their overall health and wellbeing. A total of 46% said that it was only fair or poor and it was likely to be worse, the longer they had been caring. Only 10% rated their health as excellent or very good. Up to 30% had health problems which they had not addressed or had delayed seeking help for because of their caring role,

'Breast scan and mammography I keep putting off, as I can't imagine if I have a lump how I can manage'. A 40-59 year old woman caring for her husband who has dementia.

Nearly 59% reported that their health was worse as a direct result of caring. Among the negative physical changes were:

- Tiredness or exhaustion (55%)
- Upper body problems (34%)
- High blood pressure and other heart problems (13%)
- Arthritis (10%)

They attributed these to a range of difficulties including:

- The constant pressure of caring (41% and up to 48% for the carers of children with disabilities)
- Stress (33%)
- Disturbed or lost sleep (32% and up to 39% of male carers)
- Moving the person needing care (31%) This got worse the longer the care situation went on (up to 38%) and for the carers of children with disabilities (43%)

'Twenty-four hour care of my son causes the fatigue and stress due to his many health problems, which I have been told has jeopardised my immune system. Constant lifting has caused the increase in back pain and strains.' A 25-39 year old woman, caring for her son, who has an intellectual disability.

Nearly a third of all carers had been injured at least once in the course of caring. This increased to 46% of parent-carers. The injuries included sprains, strains, cuts, bruises, bites and even fractures and dislocations. Six percent of male carers had suffered hernias.

The report estimated that the annual injury rate for informal carers was five percent. If this figure is extrapolated to the 450,900 private primary carers identified by the ABS survey, the number of carers likely to be injured each year is 22,500. The cost of this (measured against work related compensation claims for paid care workers) would be \$144 million. Only two percent of family carers received any financial

Continued Overleaf...

Synergy Summer 2000

compensation for their injuries. All the costs - physical, financial and personal - of deteriorating health due to caring are borne by carers themselves.

'Don't blame me for being bitter. I was five weeks in hospital, nearly died and struggled to walk after major surgery. I got not one cent for all the years I have been a carer and no deductions from my income tax.' A woman 75+ years of age, caring for a relative who is frail and has an intellectual disability.

Of carers who were injured, 60% got worse because they had no choice but to continue their caring work. At least half the respondents had never received information on how to avoid injuries.

Two-thirds of carers said that their mental/emotional wellbeing had been affected by caring, with 85% feeling worse. Most were sad or depressed and anxious or worried. Smaller numbers mentioned being mentally exhausted, stressed, bored, frustrated and easily upset.

Most (51%) attributed these problems to the stress of caring, social isolation, loneliness, changing relationships, loss and grief. Worsening physical health and being unable to continue paid work were also significant factors for some carers.

The only positive change reported by a statistically significant number of carers (about 10%) was a sense of satisfaction or fulfillment from the caring role. Parent-carers were less likely to feel satisfied or content, but some said they were mentally stronger and were more understanding, accepting or considerate.

'Caring has made me stronger and more assertive. It has led me back to my faith, which has been a wonderful influence on my life.' A 40-59 year old woman, caring for her parents who have dementia and other health problems.

Thirty-four percent said they did not have enough practical support, with the figure rising to 46% among parent-carers. The kinds of practical support they wanted included respite (32%) emphasising their need to rest and to have their own health problems treated. Support groups were valued by 30% and more home help of various kinds by 23%.

Only 44% felt they were receiving enough emotional support. Mostly this came from family members, other relatives, friends and neighbours. It was valued most highly by 57% of respondents.

Thirty-seven percent said that the behaviour of the person they cared for caused them the most stress. This included mood swings, anger and various kinds of abuse. Grief and loss and inability to communicate with the person being cared for were significant for 13% of each. Contact with service providers was also seen as stressful, especially for carers of children with disabilities (16%).

Carers' ways of coping centred on having a break or tuning out.

Eighteen percent enjoyed gardening or nature, 18% read, 13% had hobbies or pastimes, 11% used relaxation techniques, 10% exercise, 10% music, 8% tried to stay positive and 8% got help from religious faith.

The survey demonstrates that carers' needs are not uniform. The carers of children with disabilities are missing out and the carers of people with challenging behaviours are particularly stressed. The report recommends that services need to take various forms to meet this diversity.

More than half the carers said that caring had a major or dramatic effect on their lifestyles and life opportunities. Most common effects were reduced or no opportunities for work, study, community involvement, travel, holidays, social life, relationships, hobbies and pastimes.

The survey shows that carers' needs are so poorly met that their health and wellbeing is in jeopardy. They are indeed being taken for granted, ignored and not heard. Very few have any real choices about how they carry out their caring role, let alone about whether they do it at all.

This survey mirrors the results of a 1998 survey in the UK and points to even more disturbing finding from the US last year, that caring is a significant factor in the mortality of carers.

'I can no longer face what is obviously in front of me. It's ironic, really, that after a lifetime of caring it will probably be me who finishes in a nursing home.' A 60-74 year old woman, caring for her husband and child who have a number of health problems. ■

Warning-Caring is a Health Hazard costs \$20
(Incl. GST and postage)
For copies please contact:
The Carers Association of Australia
PO Box 3717
Weston ACT 2611
Tel: 02 6288 4377
Email: caa@carers.asn.au

Reciprocity in Education, South Australia

The ideas that underpin the Reciprocity in Education Project are based upon the belief that an absence of local services, or lack of culturally appropriate or sensitive services can and will prevent access of individuals or groups to effective treatment for mental health problems across the lifespan.

The chief outcome of this project will be the design of an educational interaction that makes use of different perceptions, values and beliefs about sadness and depression held by Migrant communities and mainstream mental health workers.

The team are working to ensure that information exchange between NESB communities and mainstream mental health workers is a two way process. This is an important aspect of the project model.

WHY DEPRESSION (BROADLY DEFINED)

Depression is the single biggest cause of disability in Australia. The effects of depression can have a devastating impact on all aspects of life, causing intense suffering to the individual, family members and friends. It is also known that depression is sometimes associated with other mental health problems, misuse of drugs, and suicide (Henderson and Rickwood, 2000).

What is less known is the way that sadness and depression is expressed within different cultural groups. Aboriginal and Torrens Straight Islanders, people from culturally and linguistically diverse backgrounds and young people are most at-risk of missing out on access to specialist services and best practice (Montgomery, 2000).

To enhance communications between mental health workers and cultural groups, the project team and community participants have been working with the broader terms of feeling down, unhappiness, emotional loss, feeling tearful or sad, rather than the more Western term of Depression.

THE MODEL OF INTERACTIVE LEARNING

Over the past six months the project team have undertaken consultations with members of the Italian, Persian and Cambodian communities on the topic of sadness and depression (broadly defined). Groups from each of the three NESB communities have been meeting in various locations across Adelaide including a primary school, a community centre and a community health service. To facilitate a 'homely-feeling' the Italian group is meeting in the home of the Chief Executive Officer of the South Australian Italian Village, Ms Marcia Fisher while she is at work.

After extensive networking and work by the project team

in the areas of developing trust, respect and effective working relations, the community groups have developed five compilation stories (two Persian, two Cambodian and one Italian) about the experiences, views and specific cultural understandings surrounding sadness and the feelings and metaphors used to describe it.

The compilation stories have been used as a basis to develop an educational interaction between the three NESB communities and mainstream mental health services. This educational interaction is highly original in the way it engages both community people and mental health workers as experts at a grass roots level.

ENGAGING WITH MAINSTREAM MENTAL HEALTH SERVICES AND THE THREE SOUTH AUSTRALIAN UNIVERSITIES

Education sessions for the three community educators to learn directly from mental health workers about the way they plan and deliver services for people with mental health problems have been implemented with the three South Australian Universities. The process of engaging mainstream mental health service staff and the three South Australian Universities was through a series of weekend workshops and seminars.

STEP ONE

Invite mental health workers from various disciplines to a workshop jointly convened by the project team. With the presence and support of the bilingual community educators, the mental health workers undertook small group-work to address and, wherever possible, suggest ideas to resolve issues raised in the compilation stories (all actions to include rationales where possible). The mental health workers were asked to design practical help for the client and their family from their perspective and present this in written form. During this process the group of mental health workers engage the bilingual community educator as a cultural guide and adviser.

STEP TWO

The project team presents practical help suggested for each of the five compilation stories back to the mental health staff for comment and clarification. Once their responses and clarifications have been incorporated, the project team translates the suggestions and solutions to each of the compilation stories into the community languages.

STEP THREE

The project team return to the Persian, Cambodian and Italian groups with the responses developed by the mental health workers in the community languages.

Where precise translations are not possible, the project team initiates discussion and seeks clarification with community participants. Community participants are asked for their constructive feedback and responses.

STEP FOUR

Each of the three community groups is presented with a summary of their feedback for clarification. Ask them to clarify it for accuracy before the project team returns to the groups of mental health workers. Wherever possible, the project team aims to generate discussion on the interface between formalised mental health services and cultural ways.

STEP FIVE

The project team returns to the mental health workers several weeks later with feedback from the Persian, Cambodian and Italian groups. The mental health workers workshop the material in small and large groups with a view to enhancing and strengthening skills, knowledge and expertise built around the topic. Ask them for anecdotal feedback on their experiences and thank them for their participation.

STEP SIX (FINAL STEP)

The project team return to the Persian, Cambodian and Italian groups for ongoing dialogue and discussion.

CULTURAL SENSITIVITY AND CAPACITY BUILDING

Occurring at the same time as the development of the educational interaction, the project team is seeking to identify areas of strength and areas for further development of their own cultural sensitivity and self-awareness. This reflective process is guided by the following questions:

1. What are the areas of strength for the groups we are working with?
2. What must we do to develop our working style with the community groups?
3. How do we approach the next group meeting?
4. What strategies are needed to help us at the next group meeting?
5. What information is needed for the next group meeting in community languages?
6. What is needed for us to ensure ongoing capacity building – actual and potential – for community participants and members of the project team?

The above questions have helped the project team and community groups better understand and relate to each other, as well as identify what practical steps are needed to ensure continued respect, growth and development.

EDUCATION AND TRAINING FOR COMMUNITY EDUCATORS

The role of community educators (Amir, Arthur and Riya) incorporates the ability to:

- Bridge gaps between mainstream mental health system and community people.
- Work between and within both worlds.
- Believe and respect the cultural values and beliefs of community people.
- Be a trusted guide and adviser and critical friend to the project and project team.
- Seek out effective ways to work with the language of emotional health and wellbeing used by participants.
- Seek out and respond to opportunities for capacity building and community development for both self and others.

A comprehensive education and training package for community educators attached to each of the three groups is being developed as the project unfolds. The package centers upon learning directly from mental health workers about the way they interpret, analyse, and intervene upon mental health issues in clinical practice.

CONCLUSION

To conclude, this educational interaction is highly original in the way that it engages both community people and mental health workers as experts at a grass roots level. At the same time, it is expected that the educational interaction between groups via the community educators will add to existing forms of mental health literacy, networking and information exchange between mental health service providers and ethnic communities. That is, a model of educational interaction that leads to increased awareness and understanding by mental health service workers of Persian, Cambodian and Italian

- Cultural formulations, beliefs and ways of knowing and responding to mental health issues and problems.

For Persian, Cambodian and Italian group members there is an opportunity to learn about the

- Understandings and views held by mainstream mental health workers that underpin their response to mental health issues for people from culturally and linguistically diverse backgrounds.

**Comments and feedback about the project are welcome. For further information please contact Dr Nicholas Procter
Telephone 08 8200 3900
E-mail: nicholas.procter@dhs.sa.gov.au**

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FRIENDS Anxiety prevention for Young People, QLD

The various FRIENDS groups being run with Former-Yugoslavian, Chinese, and mixed NESB children and youth in Queensland have been completed. The data obtained from the post-assessment phases of the project are currently being scored and entered into one large SPSS data file at Griffith University.

While participants offered many valuable recommendations to improve the cultural sensitivity of the program, preliminary results obtained from the treatment integrity and social validity data suggests that the FRIENDS program was received very well by the majority of participants. Treatment integrity data was collected in all FRIENDS groups, giving participants the opportunity to reveal what they learned in each session, what activities they liked/disliked, what they were able to understand and competently practice, and what components they felt were culturally appropriate/inappropriate. In addition to contributing to the development of a new ethnically sensitive FRIENDS manual, this data together with other resources, has provided researchers with an indication that program achieved its purpose.

The analysis of pre-treatment assessment data is complete. The data for the most part indicate that bicultural adjustment, social support, and clear self-identity serve as protective mechanisms against anxiety and trauma, and are positively related with coping ability. The main findings from this investigation indicate that child and adolescent migrants to Australia experience greater symptomatological variance between ethnic groups (former-Yugoslavian, Chinese, and mixed-ethnic), than within their ethnic groups (gender, age, or other mono-cultural variables). The first draft of the Griffith University NESB FRIENDS program was completed in August 2000, and has subsequently undergone one comprehensive revision. On September 26th, 2000, the revised draft was disseminated to members of the domestic research team for comments and feedback. Similar to FRIENDS, the new program is aimed at preventing the development of anxiety and depression. This is achieved through increasing individual's emotional resilience and promoting positive coping skills in a way that is sensitive to cultural differences.

The Group Leaders manual is a general guideline and does not target any one particular group. It is designed for high school NESB adolescents (aged between 12 and 16 years) and is general enough to incorporate both old and new immigrants and refugees, as well as political, religious, and personal differences. The flexibility of the program is of utmost importance. This draft will continue to evolve and be revised with both the information obtained from Transcultural FRIENDS groups interstate, and experiential input from the management team.

Throughout the course of the project, it has become evident that there are numerous community needs which have not been addressed as they are beyond the scope of the present study. Specifically, existing initiatives with the FRIENDS program for children and adolescents need to be expanded to help parents (a) assist their children and adolescents to cope with the stress and anxiety associated with migration, and (b) build resiliency against individual emotional and interpersonal difficulties. To do so, the cultural, intergenerational, and social variables which promote existing strengths, coping, and protective mechanisms in NESB families, and prevent adjustment difficulties and intergenerational conflict need to be further delineated for specific cultures from the assessment data obtained over the last two years. In meeting the needs and strengthening culturally specific parent-roles, the FRIENDS program will be better able to promote and enhance parent-child relationships in accordance with cultural values/beliefs. In response to these un-addressed needs, the NESB project team together with collaborative agencies in Queensland and Victoria, submitted a project proposal and funding application to the Family Relationships Branch: Department of Family and Community Services (Canberra) in October, 2000.

Robi Sonderegger
National Project Coordinator
Ethnic FRIENDS program
Griffith University, Gold Coast

NESB Mental Health Shared Care Project, QLD

The NESB mental health shared care project has completed its first major data collection phase with two groups of GPs collecting information on consultations with patients from NESB with depression and/or anxiety. Information was collected on 1,984 consultations with patients of NESB and the preliminary analysis is providing some interesting insights. The prevalence figures for depression and anxiety are high (14%) compared to the prevalence data collected by the National Survey of Mental Health and Wellbeing (1999) which reported that 9.7% of adults in the Australian population reported symptoms of anxiety disorders and 5.8% reported depressive disorders.

A significant difference between the GPs who were trained in shared care by the project and those that did not receive any training is shown in the data where GPs recorded their actions taken in response to the consultation with the patient. In 75% of consultations the GPs who have not been trained in shared care recorded "no further action taken" compared to 2% of trained

GPs who recorded a range of actions including follow up consultations, referrals, counselling and liaison with other mental health professionals.

Although the GP sample is small and results can therefore not be generalised, the data does provide some significant insights into prevalence and the impact of the training provided to GPs.

The project will have a new project manager commencing in January 2001 as Rita Prasad-Ildes leaves to take up the position of manager at the Qld Transcultural Mental Health Centre. Marco Ramirez will be taking over and for further information please contact Marco at the Brisbane Inner South Division of General Practice.

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Email: mramirez@bisdiv.com.au

Transcultural Mental Health Project, Tasmania

The advisory group for this project has been formed and two meetings were held to discuss issues around Transcultural mental health. They include representatives from North, North West and South Tasmania.

Following is a summary of the needs assessment conducted when the project commenced to investigate the needs and issues of people from culturally and linguistically diverse background and service providers. This was to gauge the level of access to services and culturally appropriate service provision for North and North West Tasmania.

Tasmania has a small and dispersed migrant community with no specific mental health services for migrants. It relies very much on the existing services to provide a service which is appropriate and culturally sensitive to the needs of migrants.

The initial findings indicated that both service providers and ethnic communities are concerned with the access to information and translated information, knowledge of services available, the stigma of mental illness, the need for language support and interpreter services, the need for understanding cultural difference, the issue of racial discrimination, and

isolation and loneliness among migrant communities.

Other issues that arose from the assessment is the lack of consideration of migrants as a specific group into the overall service planning, and the lack of policy to guide the implementation of services in Tasmania.

Future developments of Transcultural mental health services in Tasmania can be based on recommendations developed through the needs assessment. It is expected that a comprehensive plan with goals and strategies for Transcultural mental health service in Tasmania can be developed in the near future.

As required by the project, the next phase of the project is to develop an information and education package for migrant services and ethnic communities. I request the continued support from ATMHN, NSW TMHC and QTMHC for information and resources.

Gloria Lee

Transcultural Mental Health Project Officer

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email: gloria.lee@mrcltn.org.au

Transcultural Mental Health Network, ACT

The ACT Transcultural Mental Health Network received funding from the Australian Transcultural Mental Health Network to coordinate activities within the ACT and to improve access to mental health services by culturally and linguistically diverse communities. This will be initially facilitated through the work of the Transcultural Mental Health Project Officer.

The Project is a community development position, identifying needs in service provision for people from culturally and linguistically diverse backgrounds. It acts in a liaison and advisory capacity to the Network, the MHS Executive, Commonwealth/ACT Government and non-Government organisations. It will establish links between mental health service providers and ethnic communities as well as the NSW Transcultural Mental Health Centre.

I have continued with the work I started whilst employed by the ACT Mental Health Services (MHS) ie the inclusion of cultural data recording in the ACT Mental Health Service database (MHAGIC); interpreter training for all clinicians, proposal for cross cultural training for all clinicians in 2001 and following through with some of the

recommendations made to the ACT MHS Executive which impact on the work to be undertaken by this project.

I have reconvened the ACT Transcultural Mental Health Network which met in October. I have also formed a Steering Committee for the project which has met twice. It has been decided that four ethnic communities will be targetted: the Italian community, the Croatian community, the Spanish speaking community and the Cantonese speaking community.

The Project has achieved a high profile in the ACT MHS. Work has commenced with both the Italian and Croatian communities and issues are already being identified so that proposals are being considered in how to improve access to MHS.

Salva Crusca
Project Officer
Tel: 02 6205 1887

Promoting Cultural Awareness in the Management of Mental Illness, WA

The Project is progressing on schedule. Contracts have been finalised and it is now 'full steam ahead'. The Project Officer recruited for this research is Dawn Barrett. Ethics approval has been sought from Curtin University of Technology. We are currently awaiting an outcome to our submission.

The direction and scope of the literature search was the first main task for the Reference Group to address. A comprehensive search of the major electronic databases and information on various relevant website, focused on clinician-client communication which are facilitated or measured through the use of tools, in the area of mental health. The search revealed the breadth of the literature in the area of cultural awareness, knowledge and sensitivity.

However, the key to the search findings was the significant gap that exists in the literature pertaining to the translation of cultural knowledge and awareness into culture sensitive practice remains elusive in mental health literature. The various contacts we have made with national and international agencies, and with key internationally renowned researchers in this field have also been productive. Our findings in the literature so far are consistent with the views of those we have consulted. All have expressed a keen interest in this research. Prototypes for the tool will soon be developed.

For further information
please contact the NSW
TMHC
Tel: 02 9840 3800

OPERATIONAL PLAN 2000-2003

The Operational Plan 2000-2003 has been finalised and will be ready for distribution early in 2001.

CENTRE REVIEW

A review of the Centre has now been completed as part of the ongoing evaluation and quality management initiative.

REVISED TMHC MISSION STATEMENT AND GOALS

One of the recommendations of the Centre Review was to revise the Centre's Mission Statement and goals. A new Mission Statement and goals has been drafted and is currently with the Steering Committee for endorsement.

PRIORITIES FOR ENHANCEMENT FUNDING

Following extensive consultations with staff, subcommittees and other key stakeholders it has been recommended that the enhancement recently received by the Centre should be utilised as follows: High priority given to clinical services, prevention and quality improvement. This includes the expansion of the Brokerage Program; prevention; promotion and resource development; education and training, with a primary focus on the development of the Postgraduate Diploma in Transcultural Mental Health. The research priority of the Centre will consist of the first two years concentrating on

Centre evaluation and quality improvement before taking on any external research work.

AWARD TO NSW TMHC AT THE NATIONAL MENTAL HEALTH CONFERENCE (THEMHS)

Myong de Conceicao accepted the Silver Award in the Consumer/Carer Program or Service category presented to TMHC at the TheMHS Conference in Adelaide in

August 2000. She accepted the Award on behalf of Vicki Katsifis and 14 carer and consumer groups for people of NESB.

GAMBLING PROJECT

Western Sydney Area Health Service (through the Transcultural Mental Health Centre) and the Ethnic Affairs Commission of NSW have been funded by the Casino Community Benefit Fund to establish a multicultural problem gambling counselling service for NSW. This will be a stand-alone service with an option to be picked up by an alternative organisation or NGO in the future.

NEW PUBLICATIONS

NESB Older People and Mental Health
This report targets the mental health issues affecting the wellbeing of older people of non-English speaking background. It documents the findings of an extensive literature and policy review on the topic, as well as service provider surveys and the outcomes of community focus group consultations in 15 community groups.

THE HEALTH NEEDS OF THE LIGHTNING RIDGE COMMUNITY

Documents the findings of a 1995/96 health needs assessment of both physical and mental health at Lightning Ridge, a remote mining community in far north west NSW.

PROCEEDINGS OF THE 1999 MEN'S MENTAL HEALTH FORUM

An exploration of mental health issues for men from non-English speaking background.

CENTRE ACTIVITIES REPORT

The report covers the period 1997-2000 and will be ready for distribution early in 2001.

The Centre's new Resource Catalogue, which lists a wide range of books, reports, audio tapes and videos, is available on www.tmhc.nsw.gov.au

news
&
views

MENTAL HEALTH PREVENTION AND PROMOTION SERVICE

NESB YOUTH MENTAL HEALTH NEEDS ASSESSMENT PROJECT

The project has obtained \$50,000 funding from the National Suicide Prevention Strategy to complete the project. A service agreement is about to be signed and the in-depth analysis of all young people's interviews by ethnicity has been completed. Currently analysing carers and service provider interviews.

NESB MENTAL HEALTH GP SHARED CARE PROJECT

Shared care arrangements are in place. The implementation phase is currently under way. Regular meetings between general practitioners, mental health service providers and QTMHC, as part of the shared care protocol, are being held.

MULTICULTURAL GAMBLING CONCERN NETWORK

The QTMHC, together with the Multicultural Development Association, arranged and delivered a half-day seminar on problem gambling within ethnic communities with Assoc Prof Alex Blaszczyński (UNSW) as the guest speaker. The seminar was well attended. A planning workshop for the network will take place on 15th November to formulate an action plan for Brisbane on problem gambling within ethnic communities. Links have been established with Qld Treasury, Gambling Policy Directorate. Marina van Kooten-Prasad is the co-convenor of the Network.

MULTICULTURAL AGED INFORMATION PROJECT

We initiated the formation of a coalition of organisations with an interest in multicultural aged issues. A project proposal has been submitted to Multicultural Affairs Queensland for an information project involving the piloting of 'unconventional' or innovative information dissemination strategies and the collection of oral histories for publication.

MULTICULTURAL DISABILITY NETWORK

Funding has been obtained for stages 1 & 2 (of a 3 stage proposal) to develop an ethnic disability advocacy organisation in Queensland. Current work includes the development of a service model, consultation document and strengthening of the network across Queensland.

Negotiations are also under way with Disability Services Queensland and Family and Community Services for operational funds. We have received unofficial word that some funds have been allocated by Multicultural Affairs Queensland for the establishment of the organisation.

TRANSCULTURAL CLINICAL CONSULTATION SERVICE

There was an increase in demand for the Clinical Consultation Service from August to early November. During this period, the service received 94 case referrals. The Service engaged 35 bilingual/bicultural consultants to provide direct services to mental health services and consumers. Approximately six (6) new bilingual/bicultural professionals were recruited. The Service will continue to recruit new workers.

JOINT PILOT PROJECT WITH ASSESSMENTS & THE ACUTE CARE SERVICE AT PRINCESS ALEXANDRA HOSPITAL

An early intervention pilot project to develop a strong partnership between the mainstream assessment service and the Transcultural Clinical Consultation Service is under way. The two services have completed the referral protocols and will organise some briefing sessions for workers in assessments and acute care services.

For further information on these projects, please contact the QTMHC
Tel: 07 3240 2833

news
&
views

Development of a Competency-based Training Package Designed to Improve Cultural Sensitivity in Mental Health Service Delivery

For further information please contact;

Peter Taplin
Staff Development Unit
Graylands Hospital
Tel: 08 9347 6600 or

Dr Bernadette Wright
Transcultural Psychiatry Unit,
Tel: 08 9224 1760

news & views

With the support of various mental health services managers, a joint submission prepared by Graylands Hospital, North Metropolitan Health Services, and Swan Mental Health Service and the Transcultural Psychiatry Unit, has recently been successful in obtaining funding from the Mental Health Division of the Health Department (WA) for the development of a competency-based training package for staff at mental health services. This initiative is consistent with one of the strategic directions contained in Western

Australia's transcultural mental health policy, which has undergone an extensive consultation phase, and is now in its later stages of development.

The concept for this project was originally developed by the Multicultural Forum for Mental Health Practitioners. Clinicians on the Forum recognized that much of the cross cultural

training offered to mental health service staff is developed without:

- a) consideration of relevance to clinical practice;
- (b) first undertaking an analysis of staff training needs; and,
- (c) identification of appropriate competencies required to ensure that cultural sensitivity and cultural awareness are employed during clinical service delivery.

Therefore, the training proceeds with an implicit assumption that staff have very little knowledge about cultural issues. The project seeks to redress the ad-hoc nature in which existing cross-cultural awareness training - which may be 'interesting', and at times, 'novel' - are developed, and offered to mental health services. Anecdotal evidence confirms that these are examples of the deterrents that

contribute to staff's lack of enthusiasm in attending such training sessions. The degree of retention and usefulness for clinical application are rarely evaluated.

A broad aim of this project is to improve the cultural sensitivity in clinical practice of staff working in mental health settings. More specifically, the project will involve the adaptation of competency standards in the development of a cross-cultural training package for mental health services. This will ensure high quality and consistent standards across the metropolitan mental health services.

A project team was convened, comprising members who could provide expertise on the units and elements of competencies that must be assessed, and included in a relevant cross-cultural training program; and, who would ensure that the training program developed is both a competency-based training package and is clinically relevant. The development of a training package, tailored to appropriate competencies, is based on the proposition that attention to cultural issues improves the quality of clinical practice and patient care.

The proposed long term outcome for this project include:

- the enhancement of clinical outcomes for people from CALD backgrounds by delivering a service that demonstrates an awareness and respect for the client's cultural framework;
- an increase in appropriate and clinically relevant cultural competency levels of mental health practitioners by improving their skills in dealing with people from CALD background; and that
- direct service delivery to people from CALD backgrounds will be non-discriminatory and non-judgemental.

Temporary Protection Visa (TPV) Issues & Early Intervention Program

TPV holders continue to confront Torture and Trauma Services with challenging service provision issues.

Australia's response to the steady numbers of unauthorized boat arrivals from central Asia and the Middle East has been to develop a new temporary visa category (785), for a period of 3 years. Applicants are Granted a Temporary Protection Visa (TPV) once the protection claims have been established.

TPV holders are entitled to basic income support and health assistance, and are not able to take part in any scheme to reunite with their families in Australia. TPV holders are released from detention with prearranged destinations in states other than NSW or Victoria.

Torture and Trauma Services are the only DIMA funded Integrated Humanitarian Settlement Strategy (IHSS) services that can assist TPV holders. Many other agencies that normally assist with the resettlement of refugees, such as Migrant Resource Centres and DIMA funded Ethno-specific organizations are not allowed to assist this group. There is still considerable uncertainty in terms of what state-funded services TPV holders are eligible for. State Government positions on this issue vary substantially.

As a group therefore TPV holders present with many of the trauma and settlement related issues we commonly work with exacerbated by frustration and anger associated with their detention experience and the additional settlement challenges they face in the absence of adequate access to settlement services. By far the worst aspect in their situation is their inability to reunite with their family while on a temporary protection visa. Clinical observations suggest that depressive symptomatology appears to be more common in this group as a result. Trust issues are also more complex and difficult to address, and attendance patterns less reliable than those of non-TPV clients from similar backgrounds.

Attempts to accommodate TPV holders in states other than NSW and Victoria have stretched the resources of some states (eg

Queensland). It has also resulted in internal migration patterns from other states to NSW and Victoria (according to Centrelink registration data over 40% of TPV holders have made their way to NSW, primarily Sydney). In the absence of specific information about available services in these states, this often results in ad hoc settlement patterns and inadequate living conditions. The fact that many of the services normally engaged to assist with these issues are not available to TPV holders compounds this problem.

EARLY INTERVENTION PROGRAM (EIP)

A 3 year contract for the provision of an early assessment and intervention program has been entered into by Torture and Trauma Services and DIMA. The functions to be performed by Torture and Trauma Services under this contract have changed slightly in the context of changes to the Integrated Humanitarian Settlement Strategy. The new contract stipulates rigorous reporting requirements. Considerable effort has been invested in adjusting data recording and processing systems to cope with the new requirements.

A national approach has been taken to address this issue, with STARTTS and VFST working together to increase compatibility between both systems, which were then made available to other states. While this has been an onerous process, it will provide the NFSSTT with a very detailed and nationally compatible data set for all humanitarian entrants assessed.

OPERATION SAFE HAVEN FOLLOW UP

A number Kosovars are still undergoing treatment for torture and trauma related psychological problems. Most of these are people who remained behind because of their afflictions, and have been granted temporary

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news & views

visa extensions for a period of three years for the purpose of undertaking psychological treatment, in light of recommendations made in a nationally coordinated report by STARTTS, VFST and TRANSACT to the Minister of Immigration, Phillip Ruddock. There are also other Kosovars remaining in Australia either awaiting status determination after being allowed to apply for protection, or who have indeed been granted protection already, and a small number of East Timorese in a similar situation. Most of these people also need ongoing psychological treatment.

Although the numbers involved are not large, they represent the most affected people from a group of 4,000 Kosovars and 1000 East Timorese that were assisted through Operation Safe Haven because of their experiences in Kosovo and East Timor. In terms of their impact on NFSSTT general services, it is roughly equivalent to having had the refugee intake increased by 4,000 people for a particular year, since usually only a small percentage of our refugee and humanitarian entrant group is likely to need ongoing counselling and other service

for a significant period of time. Negotiations continue to obtain funding for this ongoing activity beyond the scope of Operation Safe Haven.

INTERNATIONAL ACTIVITIES

Several Forum members (STARTTS, VFST, ASeTTS and TTSSNT) continue to have significant involvement in the Psychosocial Recovery and Development in East Timor (PRADET) Project, acquisition of agencies which also includes the NSW based Psychiatric Research and Teaching Unit (PRTU) as leading agency and NSW and NT branches of the Australian Association of Social Workers. PRADET is the prime agency developing services to address torture and trauma and general mental health needs in East Timor. Significant gains have been made in the last few months both in the development of basic psychiatric counselling and psychosocial services, and in the training of East Timorese mental health care workers and capacity building in general.

MINIMUM NATIONAL DATA SET

Work continues towards the development of a national database for general services (as opposed to Early Intervention Program) clients. The first trial of a minimum national data set has been undertaken.

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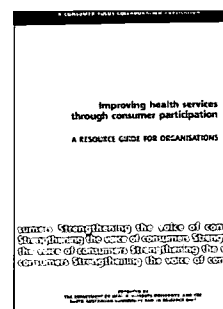
Enquiries and bookings to the Editor on (02) 9840 3331

Improving health services through consumer participation: A resource guide for organisations

Improving health services through consumer Participation is the first of the Consumer Focus Collaboration publication series.

This document was developed under the name of the Consumer Participation Tool Kit. It was prepared as a tripartite project involving the Consumer Focus Collaboration, the Consumers' Health Forum, and the Health Advisory Committee of the National Health and Medical Research Council.

The Commonwealth's Consumer Focus Strategy encompasses a range of projects to strengthen consumer participation in health which are overseen by the Consumer Focus collaboration. The Collaboration is made up of consumer organisations, professional organisations, health departments, and private sector representatives. The Collaboration works to increase effective consumer participation at all levels within the Australian health care system, with a view to improving the quality of health services.



For further information please contact the National Resource Centre for Consumer Participation in Health. Tel: 03 9479 3614 or 1800 625 619. The website is <http://nrccph.latrobe.edu.au>

Ethnicity and disability factbook

On 8th of December 2000 an innovative, 'all you ever wanted to know, but never dared to ask', 70 page Factbook on Ethnicity and Disability was launched by the Multicultural Disability Advocacy Association (MDAA) of NSW. The aim of the Factbook is to provide a resource book and starting point for disability and generalist workers, wanting to know more about the cultures and religions of their consumers and wanting to provide a better, culturally more competent service.

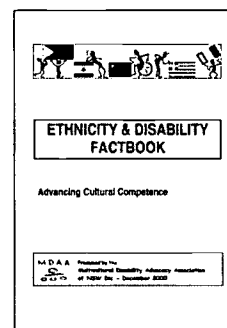
There are three different sections in the Factbook:

ETHNICITY & DISABILITY gives you an overview of the issues, and aims to help you understand and further develop and strengthen your theoretical framework of working in a culturally diverse society.

RELIGIONS gives you a brief overview of the five main religions practiced in NSW. Under each religion you will find the numbers of people practicing, the origins and the sacred texts, the beliefs and practices, the different strands of each religion, as well as a discussion on some of the common myths held about each one of the religions.

COMMUNITY PROFILES gives an overview of nine communities in NSW. Each community profile is structured in the same way and you will find information on the people; some background; the story of migration, some cultural aspects of community life and a discussion about attitude/s towards people with disability.

Gustav Gebels, Vice- Chairperson of MDAA said at the Launch: There are people from 276 countries speaking some 241 different languages living in NSW (ABS Census, 1996). No one person can know all about these cultures and languages. The solution to better service provision in a culturally diverse community does not lie with trying to become an expert in all cultures, but with identifying concrete strategies and actions that reduce the barriers for people from NESB with disability and enhance the quality of service provision. Learning more and enhancing ones' understanding of cultures and religions is one such strategy.



If you would like to order a copy please contact
MDAA of NSW
Tel: (02) 9891 6400
Fax: (02) 9635 5355
E-mail: mdaa@healey.com.au

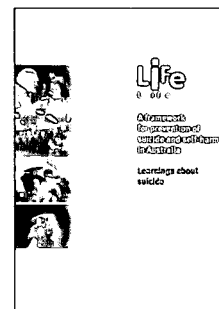
Living is for everyone (LIFE): a framework for prevention of suicide and self-harm in Australia

More than 2500 Australians of all ages and from all walks of life die by suicide each year and many more deliberately harm themselves. These acts are associated with profound distress, not only for the individuals themselves but also for their families, peers and the wider community.

Living Is For Everyone (LIFE): a framework for prevention of suicide and self-harm in Australia has been developed to tackle suicide and suicidal behaviour among all sections of the community.

The LIFE Framework was developed by the National Advisory Council on Youth Suicide Prevention and involved extensive community consultation.

The LIFE Framework is a resource from all sectors of the community. It has been prepared to inform agencies, organisations and governments at all levels of current national priorities and directions in suicide prevention. It can assist with planning and conducting suicide prevention programs and support evidence based approaches to suicide prevention. It may also be of value to other people in the community who have an interest in suicide prevention including families, volunteer and support networks, as well as researchers and students.



Copies of the LIFE Framework can be ordered from the Commonwealth Department of Health and Aged Care on
Tel: 1800 066 247

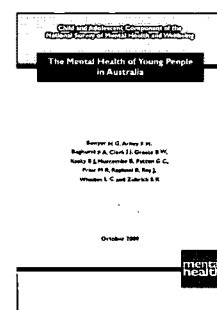
The mental health of young people in Australia: Child & adolescent component of the national survey of mental health and

The Mental Health of Young People in Australia represents the third component of the National Survey of Mental Health and Wellbeing. The child and adolescent component of the survey was conducted in late 1998 and the purpose was to determine:

- The prevalence and nature of mental health problems in children and adolescents ages 4 to 17;
- The degree of disability associated with these problems; and
- The services used by children and adolescents with a mental health problem.

The survey has several strengths. Firstly, it has benefited from the development during the past decade of improved instruments for assessing the mental health and quality of life of children and adolescents. The availability of these instruments has made it possible to obtain a clearer picture of the mental health and wellbeing of young people in Australia.

Second, the survey obtained information about a broad cross-section of children and adolescents in different regions of Australia. This ensured that the results would be representative of a wide range of young people and finally, the large number of participants has allowed detailed study of the characteristics of children, adolescents and families associated with mental health problems.



The report can be obtained from;
Mental Health and Special
Programs Branch
Tel: 1800 066 247
The full report can also be accessed
from the Branch's website:
www.mentalhealth.gov.au

The third part of the model - skills - refers to specific tools needed for everyday work with patients or clients from an increasing number of ethnic minorities: e.g. working with interpreters, performing a cultural assessment, verbal and non-verbal communicating cross-culturally, and repairing misunderstanding when things go wrong.

PROFESSIONAL DEVELOPMENT

Clinicians of all health disciplines need to have the opportunity to revitalise their approaches to their interactions with patients or clients, whatever their cultural origins. There is much ongoing anecdotal evidence of the problems experienced by clinicians when there is cultural distance between themselves and their clients. They report feelings of frustration, inadequacy and bewilderment in terms of carrying out assessment, diagnosis and treatment when cultural issues add an unknown dimension to standard precepts laid down in professional training.

In order to accommodate the requirements of a range of mental health practitioner roles, the VTPU conducted a series of needs analyses not only for content as mentioned above but also of teaching mode of delivery. As the education of mainstream mental health professionals is a challenging and dynamic field, it was important to find a useful teaching style that would make the best use of the short time available to most busy practitioners. It was indicated to the educators that there is a need for an interactive approach which encourages course participants to examine their own professional cultures as well as ethnic cultural background in order to appreciate their impact on a multicultural clientele where expectations and behaviours are not always clearly understood. This concept is frequently a new and different one for the mainstream

practitioner who is used to examining only client or patient issues, and not service provider ones.

POSTGRADUATE EDUCATION INITIATIVES

The VTPU has made a contribution to transcultural mental health at different levels of postgraduate education. This implies an expertise in the field of cross-cultural methodology and analysis, which has been consolidated under the leadership of Steven Klimidis. Over the eleven years of VTPU operation, a total of fourteen PhD, doctoral and research Masters students have worked on significant projects supervised by VTPU staff. Areas of investigation range over the following broad topics of migration and the adjustment process, the relationship of culture and psychopathology, and culturally appropriate services. Some of the cohorts researched include Chinese-Australian elderly, Polish elderly, Hong Kong and Australian elderly, Malaysian parents and children, NESB patients, South African adolescents, and urban and regional Australian indigenous communities.

In 1996, the VTPU launched the first Graduate Diploma in Mental Health Sciences (Transcultural Mental Health). This course was aimed at students from a range of professional backgrounds working in the area of mental health and associated disciplines, including psychiatry, general medicine, psychology, occupational therapy, psychiatric nursing, social work and counselling. For the next five years, some forty students completed selected units or the whole course in part time or full time mode. This has provided them with a solid basis in migration, refugee and indigenous issues, epidemiological studies, cross-cultural assessment and treatment, the relationship of culture and health, and the complementary areas of social policy, service delivery and cross-cultural research and evaluation. Each completing student

has been required to produce a 10,000 word thesis based on original cross-cultural research in conceptual, qualitative or quantitative modes. Many students were inspired to choose research in their own area of work or ethnic group. A range of topics of great usefulness and transcultural interest have included aspects of the following: Vietnamese elderly attitudes to changing family dynamics; service development for increasing indigenous access; practitioner attitudes and knowledge regarding indigenous mental health; the place of religion in relation to schizophrenia; mental health promotion for NESB people; transcultural nursing curriculum content; transcultural training needs of mental health staff; potential risk factors for immigrant adolescent psychopathology; support services programs; service development for the Deaf community; and, Bosnian community attitudes regarding sexual assault.

FUTURE INITIATIVES IN PROFESSIONAL EDUCATION

We continue to receive requests for the delivery of distance education programs. In order to fulfil the needs of practitioners both on-shore and off-shore, the next logical step will be to develop and implement on-line programs using computer and internet based technology, not only to serve people far away from Melbourne but also to make on-going professional development available at any time in a busy work schedule at the convenience of the learner. Other advantages to a new on-line teaching mode would include the ability for learners far away from each other to engage in dialogue and collaborative projects on subjects of mutual interest and benefit.

With Australian Transcultural Mental Health Network support, we have begun the exacting - and exciting - task of transferring material from our face-to-face teaching program to the new

Continued overleaf

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world of cyberspace, where different educational strategies will be engaged to match the developments in the technology available. The use of e-mail will play a prominent part in instructing, discussing, assessing, and socialising the learning cohort. It is expected that a professional development program may begin with a 'public' level of accessible material, which will then be available at 'deeper' and more complex award course levels, be they graduate certificate, graduate diploma and master's degree levels.

COMMUNITIES, CONSUMERS AND CARERS

The VTPU has always been interested in community education and the perspectives of carers and consumers. We have developed models for community education about mental health by using interpreters with language specific groups. This has been piloted with Horn of Africa and Lebanese women's welfare groups. On each occasion there has been great enthusiasm for the sessions, and a very strong interest and commitment to learning more about vital aspects of health in Australia which may improve

the lives of those in their community needing help.

Another model we have tried out involves supporting the teaching and information giving initiatives of a pan-African group who are interested in bridging the gap between mainstream health providers and African communities. This model is really an extension of a 'train the trainer' program, which we have developed and delivered to health personnel who wish to train their colleagues in transcultural concepts and techniques.

Both the above models have great potential for reaching out to all culturally diverse groups at all levels of acculturation and literacy. It now behoves us to find the resources to promote, develop and deliver programs of these types to all groups who would benefit from them. In addition we need to address the specific needs of carers and consumers by approaching this within the context of their own ethnic communities. To this end we have begun dialogue with psychiatric disability support groups whose outreach work will inform this process, and with whom we will work collaboratively.

WHAT HAVE WE BEEN ABLE TO DELIVER SO FAR?

So far we have delivered a variety of relevant topics at a range of levels to health and welfare practitioners. We now need to extend the programs to include a greater range of directly applicable clinical topics to enhance the established generic content. The collaborative work with ethnic mental health consultants based in various area mental health services throughout Victoria has been a satisfying and useful activity, and has produced a range of programs for practitioners across all sectors of adult, aged, child and adolescent mental health services. However at the same time we need to focus on the wider community where there is a great need for education about mental health and the support education brings in its wake. This should be extended to include programs with increased community, consumer and carer focus, designed to open up hitherto unknown areas like consumer and carer support, and community education, seen through the eyes and experience of ethnic community members. Until this is achieved the job is only half done. □

WEBSITES ON PROMOTION, PREVENTION AND EDUCATION

MENTAL HEALTH RESOURCE CENTRE

www.span.com.au/mhrc/

MENTAL HEALTH COUNCIL OF AUSTRALIA

www.mhca.com.au

AusEinet - AUSTRALIAN EARLY INTERVENTION NETWORK

<http://auseinet.flinders.edu.au>

EARLY PSYCHOSIS PREVENTION AND INTERVENTION CENTRE

<http://home.vicnet.net.au/~eppic/>

NSW MULTICULTURAL HEALTH COMMUNICATION SERVICE

<http://mhcs.health.nsw.gov.au/health-public-affairs/mhcs/>

MENTAL HEALTH BRANCH of DEPARTMENT OF HEALTH & AGED CARE

www.health.gov.au/hsdd/mentalhe/

Events Calendar

2001

Feb

15-16 **Supporting Women Survivors of Sexual Violence: A 2 day training conference**

Bardon Conference Centre, Brisbane
Tel: 07 3843 1823
Email: zigzag@irvnet.org.au

19-21 **4th Australian Women's Health Conference: Political Action and Engagement**

Adelaide Convention Centre, Adelaide
Tel: 08 8363 1307
Email: info@fcconventions.com.au

March

4-7 **Good Health - Good Country**
6th National Rural Health Conference
National Convention Centre Canberra

Tel: 02 6285 4660
Fax: 02 6285 4670
Email: conference@ruralhealth.org.au

28-31 **4th National Conference Infant Child & Adolescent Mental Health**

Australian Infant, Child, Adolescent and Family Mental Health Association

Carlton Crest Hotel, Brisbane
Tel: 07 3858 5563
Email: mha2001@im.com.au

April

7-9 **Suicide Prevention 2001: A Human Odyssey - 8th National Conference of Suicide Prevention Australia**

The Sydney Convention and Exhibition Centre, Darling Harbour, Sydney
Tel: 02 9211 1788
Email: conference@suicidepreventionaust.org

May

21-24 **Causes**

The Royal Australian and New Zealand College of Psychiatrists 36th Congress
National Convention Centre, Canberra
Tel: 02 6257 3299
Fax: 02 6257 3256
Email: ranzcp2001@ausconvservices.com.au

28-30 **Diversity in Health: Sharing Global Perspectives:**

2nd ATMHN Conference
3rd Australian Mental Health Conference
6th NSW TMHC Conference

Sydney Convention and Exhibition Centre, Darling Harbour, Sydney
Conference Secretariat
Tel: 02 9518 9580
Email: diversity@pharmaevents.com.au

June

27-28 **Health Outcomes 2001: The Odyssey Advances**

7th Annual International Health Outcomes Conference, Canberra

Tel: 02 6205 0869
Fax: 02 6205 2037
Email: jan.sansoni@act.gov.au

August

27-30 **No One is An Island**

11th Annual TheMHS Conference
Wellington, New Zealand

Tel: 02 9926 6057
Fax: 02 9926 7078
Email: enquiries@themhs.org

Synergy Summer 2000

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 NSW 2150
 Australia

SUMMER 2000

Synergy is a quarterly newsletter published by the Australian Transcultural Mental Health Network.

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Contributions to this newsletter do not necessarily reflect the views of the ATMHN.

Australian Transcultural Mental Health Network

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Australian Capital Territory

ACT Transcultural Mental Health Network (02) 6207 1066
 Health Outcomes, Policy & Planning,
 Department of Health & Community Care (02) 6205 0877

Commonwealth

Department of Health & Aged Care,
 Mental Health Branch (02) 6289 7722

Community / Consumer / Carer Associations

Australian Mental Health Consumers Network (07) 3394 4852
 Carers Association of Australia Inc (02) 6288 4877
 Federation of Ethnic Communities
 Councils of Australia Inc. (02) 6282 5755
 Mental Health Council of Australia Inc. (02) 6285 3100
 National Ethnic Disability Alliance (02) 6290 2061
 National Forum of Services for Survivors
 of Torture and Trauma (02) 9794 1900

New South Wales

Mental Health Branch, NSW Department of Health (02) 9391 9299
 NSW Transcultural Mental Health Centre (02) 9840 3800

Northern Territory

Mental Health, Aged & Disability Services,
 Territory Health Services (08) 8999 2916

Queensland

Mental Health Unit, Queensland Health (07) 3234 0674
 QLD Transcultural Mental Health Centre (07) 3240 2833

South Australia

Mental Health Unit,
 SA Department of Human Services (08) 8226 6275
 SA Transcultural Mental Health Network (08) 8130 1300

Tasmania

Mental Health Program, Department
 of Health & Human Services (03) 6233 4750

Victoria

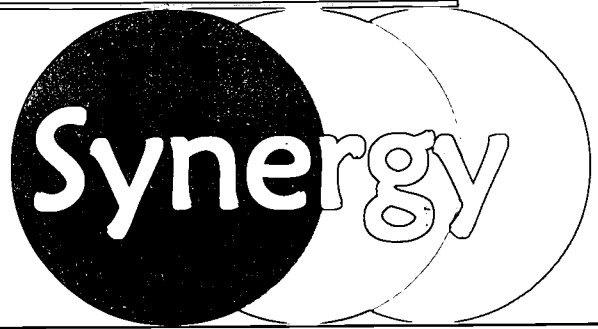
Aged, Community & Mental Health,
 Department of Human Services (03) 9616 8123
 Victorian Transcultural Psychiatry Unit (03) 9417 4300

Western Australia

Mental Health Division,
 Health Department of Western Australia (08) 9222 4099
 WA Transcultural Psychiatry Program (08) 9224 1760

The Australian Transcultural Mental Health Network is an initiative supported by the National Mental Health Strategy and funded by the Commonwealth Department of Health and Aged Care.

**national
 mental
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Diversity in Health: Sharing Global Perspectives

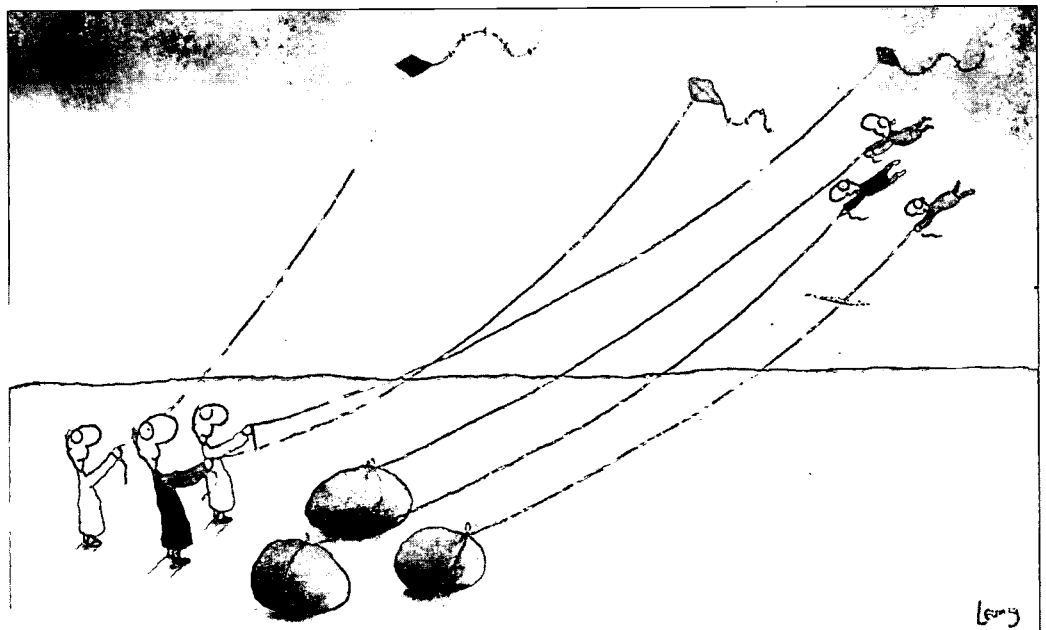
The Australian Transcultural Mental Health Network is proud to announce that its 2nd National Conference will be held in partnership with the 3rd Australian Multicultural Health Conference and the 6th NSW Transcultural Mental Health Centre Conference.

Diversity in Health: Sharing Global Perspectives, at the Sydney Convention and Exhibition Centre from May 28-30, 2001, will be a landmark event in Australian multicultural health. National and international speakers and conference delegates will discuss the spectrum of issues relating to the health and well-being of culturally and linguistically diverse communities.

I urge all Synergy readers to mark the Conference date on the calendar for May next year. Join us as a delegate or better still, present a paper, workshop or poster.

Use the fax back flier in this edition of Synergy to join the conference mailing list, contribute to the conference program and receive up to date information and early bird registration.

Emeritus Professor Beverley Raphael
Chair, Diversity in Health National Steering Committee



"The Different Needs of Different Men"

The Different Needs of Different Men, by Michael Leunig, is reproduced from his book YOU AND ME, published by Penguin Books.

ONE IN 20 THINK OF KILLING THEMSELVES

At any time, one in 20 of us is thinking of committing suicide.

A report on Suicide by Adelaide University and recently published in the Australian & New Zealand Journal of Psychiatry states that depression is the single most important factor behind suicide.

Researchers reached this conclusion after a telephone survey of 2 500 adults. The study highlighted the view that although suicidal thoughts could take place in people confronted with difficult situations, they were more common in people already seriously depressed.

The study found the main external stresses were a marriage or relationship breakdown, the death of someone close, a serious illness, being discriminated against, moving house or being robbed. Poverty was also a factor.

Reported in the Sydney Morning Herald 2/2000

STANDARDS FOR STATISTICS ON CULTURAL AND LANGUAGE DIVERSITY

The Australian Bureau of Statistics has developed a Standards for Statistics on Cultural and Language Diversity in response to a widely recognised need for a nationally consistent framework for the collection and dissemination of data on cultural and language diversity. The publication presents a set of statistical standards which are designed to collect all the cultural

and language information considered necessary for consistent and accurate measurement of cultural diversity in Australia. The standards are intended as a replacement for non-English speaking background (NESB), which has previously been used as a broad measure of culturally related need or disadvantage.

AUSTRALIA'S YOUNG PEOPLE: THEIR HEALTH

This report by the Australian Institute of Health & Welfare is the first national report to focus entirely on the health of young Australians.

Some of the findings include:

Mental disorders account for more than half the total youth disease burden to the community;

Suicide rates for young men has increased 71% between 1979 -1997;

1 in 5 young men and 1 in 10 young women in the 18-24 years age group had a substance use disorder.

MACQUARIE LEARNERS DICTIONARY

The Macquarie Library has produced its first dictionary for learners of English. The dictionary informs the reader on pronunciation, grammatical information and word family.

MIGRANTS HAVE JOB SUCCESS

Nearly three in five migrants have a job within three years of arriving in Australia, a recent study from Adelaide's Flinders University has reported.

The report has also found job prospects improved for immigrants the longer they are in Australia.

Those who arrive on a job-related or skills visa were more likely to find work than those who came as refugees or through family ties.

Yet refugees reported higher levels of satisfaction with life in Australia than those from other visa categories, 92-94 % feeling their decision to migrate was the right one.

Reported in the Canberra Times & Daily Telegraph, Sydney 22/2/00

First Step Towards National Mental Health Institute

In a speech to the National Press Club in Canberra on February 16, NSW Premier Bob Carr called for increased links between mental health researchers and organisations as a step towards setting up a National Institute on Mental Health

Former Victorian Premier Jeff Kennett last year raised the issue of a National Institute on Depression, but Mr Carr has developed this into a broader proposal covering all mental illness and based on the model of the National Institute of Mental Health in the US.

Mr Carr has written to the Prime Minister requesting that the issue of the Institute be placed on the agenda of the next Council of Australian Governments meeting.

The Cultural Competence in Victorian Child & Adolescent Mental Health Services (CAHMS) Project Stage 2

Jennifer J. Luntz
Victorian CAMHS Project Officer

This article describes a Project conducted with the fourteen Victorian Child and Adolescent Mental Health Services (CAMHS) (six in Melbourne and the remaining eight in rural and regional Victoria) to assist them improve their responsiveness to CALD children, adolescents and families. The Project sought to make needed changes in something of a Federal and State policy vacuum. Because existing policy provides direction to improve assessment and equity to mental health services for CALD adults, their needs and mental health problems are often very different from those of the younger members of our community. In consequence such policy is not applicable or appropriate for children without modification.

The Project known as the Cultural Competence in CAMHS Project Stage 2 was based on work done with two metropolitan CAMHS (CAMHS NESB Project Stage 1) which had culminated in a report launched in March 1998 (Luntz, 1998). This report made ten recommendations. The Project Brief for Stage 2 sought to implement some of the recommendations made in the Stage 1 report.

The aim of the project was to increase the responsiveness of CAMHS to consumers from a NESB(1).

Objectives;

To map the current policy approaches of each CAMHS in Victoria to the needs of their NESB population;

To assist each CAMHS develop a strategic plan for the provision of culturally sensitive best practice to NESB consumers;

To assist each CAMHS identify and maintain ethno-specific partnerships to better meet the needs of consumers and provide a more integrated service to CAMHS consumers from a NESB;

To identify cross-cultural training needs of CAMHS as they arise in the consultation process (Project Brief, August 1998).

PROJECT STRUCTURE

The Project worked with the fourteen Victorian CAMHS. Funding allowed for the appointment of a half-time project officer for twelve months and project management by the Mental Health Promotion Officer (MHPO) at the Austin and Repatriation Medical Centre CAMHS. A Steering Group with representation from country and metropolitan CAMHS; the VTPU and an Ethnic Mental Health Consultant (EMHC) guided the work of the Project. It was chaired by a senior project officer from the Department of Human Services, Mental Health Branch (MHB).

The tight timelines; half time status of the Project Officer; distances to be travelled to visit country CAMHS; other policy implementation demands being made of CAMHS during 1999; and the fact that this was the first attempt by Victorian CAMHS to focus on the mental health needs of CALD young people, necessitated that the goals be modest.

Continued overleaf

Synergy Autumn 2000

Each CAMHS developed a structure comprising a contact person with whom the Project Officer could liaise, and a core group to support the contact person. The size of the core group was determined by the size of the CAMHS and what was presumed to be the size of the CALD populations living within the catchment area. At the very least it comprised one clinician; the MHPO attached to the CAMHS; and the EMHC in whose region the CAMHS fell. Representation from front-line administrative staff was encouraged and active support from management considered essential if the changes were to be maintained beyond the life of the Project. To ensure support from management the Assistant Director of Mental Health wrote to each CAMHS introducing the Project and Project Officer at the beginning.

Links between the Project Officer and Contact Persons were by phone, fax and letter (email being unavailable in most CAMHS). At least one site visit was made to each CAMHS. Others were arranged as requested. The core group members and interested others attended two forums to meet and work on some tasks.

PROJECT TASKS

The Project Brief's requirement that each CAMHS map the current policy approaches was split into two tasks, an internal mapping exercise which asked each CAMHS to discover structures and practices relating to CALD clients within their clinic; and an external mapping exercise where the task was to learn about the range and size of the ethnic communities living in the catchment area; the ethno-specific and ethno-generic agencies which service these communities as well as those mainstream services reputed to work well with ethnic communities.

THE INTERNAL MAPPING EXERCISE

Through the internal mapping exercise it emerged that most city

CAMHS did not hold copies of such policy documents as Victoria's Mental Health Services: Improving Services for People from Non-English Speaking Background (1996). Nor did several of them know about the policies of their host Hospital (and the psychiatry departments within them), towards servicing CALD communities. Country CAMHS are managed through adult mental health services and they produced service-wide policies which gave scant consideration to the issues confronting CAMHS where the problems include serious emotional disturbance; behavioural disorders and inter-familial strife in addition to serious mental illness.

The internal mapping exercise informed each CAMHS on the use of interpreters by their staff; whether staff had attended training in working with interpreters and/or in culturally sensitive therapeutic interventions. The exercise raised the consciousness of clinical staff about the need for case presentations on CALD clients; alerted them to the fact that they needed to include CALD carers and consumers in their feedback loops; identified the numbers of bilingual/multicultural staff (both clinical and administrative) employed and the extent to which these workers could be called upon to use these skills.

THE EXTERNAL MAPPING EXERCISE

The external mapping exercise enabled each CAMHS to discover which ethnic groups lived in their catchment area and encouraged contact with the ethno-generic and ethno-specific agencies which serve them. This was instructive for both sides, since many such services had had little previous experience of CAMHS and did not know when and how to access them. Through consultations with these newly formed contacts each CAMHS chose one of the ethnic groups living in their catchment area to profile in greater detail. They tackled this task in

different ways. Some interviewed the staff employed in these agencies. Others used the agencies to gain contact with, and interview community members. A forum brought twenty-five interested CAMHS clinicians together one afternoon to share what had been learnt about the following communities: Horn of Africa in Western Metropolitan Melbourne; the Somali community in Inner South East Melbourne; the East Timorese Asylum Seekers in Richmond; the Cambodians of Springvale; the Chinese from Box Hill; the Bosnians of Geelong; Filipino families in both Ballarat and Bendigo; and the Albanian community in the Goulburn Valley (Shepparton). Several country CAMHS couldn't make the journey so the group was unable to hear about the Turkish community in Mildura; second generation Italians in the Wodonga/Wangaratta area and Bosnians in the La Trobe Valley. The profiles will be collated and be available in hard copy and on the ATHMN website in due course.

It is hoped that CAMHS workers find this task so personally rewarding and useful that they will select a different ethnic community each year to work with. If they do, over time they should become knowledgeable about, and develop partnerships with, all communities in their catchment areas.

EXTRA DATA COLLECTION

In Victoria currently, data is only collected on the usage of mental health services by first generation migrants. Since most CALD children and adolescents in Victoria are in fact second generation, CAMHS figures on the use of their services by CALD clients is inaccurate. To obtain a more accurate snapshot, for the month of August all the CAMHS asked questions about parents' country of origin, length of time each parent had lived in Australia, preferred language of each parent as well as language spoken at home.

Book Review:

Mental Health Consumer Participation in a Culturally Diverse Society

Andrew Sozomenou, Penny Mitchell, Maureen Fitzgerald, Abd-Elmasih Malak, Derrick Silove

In March, the Australian Transcultural Mental Health Network and the Transcultural Mental Health Centre, NSW, launched the monograph 'Mental Health Consumer Participation in a Culturally Diverse Society'. The monograph weaves together the threads of participation and partnerships through the lived experiences of consumers and carers. Using the experiences of eighty consumers, carers and staff from eight organisations around Australia, the monograph provides the first comprehensive and practical introduction to the challenge of mental health service partnerships involving consumers and carers from culturally and linguistically diverse backgrounds.

The recognition at Commonwealth and State Government levels of the importance of consumer and carer participation in the development and evaluation of mental health services provides an ideal opportunity for increasing the appropriateness of such services for culturally and linguistically diverse communities. This opportunity, however, will only be realised if community participation mechanisms are established that truly reflect the diversity of communities and if services are truly responsive to the ideas and viewpoints expressed in these forums.

I find it positive to see the viewpoints of staff, consumers and carers in a single document - too often these are reported separately. This document is to be commended as it demonstrates true acceptance and participation of all stakeholders

Gwen Scotman, NSW Delegate and Deputy Chair
Australian Mental Health Consumer Network.

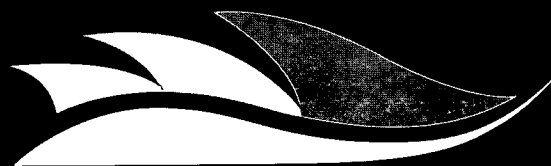
The demographic profile of Australian society, which is the most culturally diverse in the world, is a reality which has implications for the manner in which mental health organisations plan, deliver and evaluate services. Groups in the community who have historically been denied equal access to services may also be denied access to participation mechanisms, unless special efforts are made to target disadvantaged and marginalised groups.

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Australian Transcultural
Mental Health Network
2nd National Conference

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Further information/expressions of interest, call 61 2 9518 9580 or email diversity@pharmaevents.com.au

**Ethnicity, immigration and psychopathology,
Language of science**

Al-Issa, I., Tousignant, M. e. 1997.
New York: Plenum Press
Corlett, D. 1999.

The Burmese new arrivals

Corlett, D.
Community Profiles Series;
Ecumenical Migration Centre.
Melbourne: 1999.

**She still won't be right mate!
Will managerialism destroy values based
medicine? Your health care at risk!**

Melbourne:
Hoffmann, T. 1999.

The Iraqi Shia Community

Hoffman T,
Community Profiles Series
Ecumenical Migration Centre,
Melbourne:1999.

**Joined hands bring success :
Gacmo wada jiraa galladi ka dhalata.
A resource for service providers working with
Somali people**

Robinson, Julian.
Community Profiles Series,
Ecumenical Migration Centre,
Melbourne:1999

**From war to Whittlesea,
oral histories of Macedonian child refugees**

Macedonian Welfare Workers.
Melbourne 1999.

**Review of illegal workers in Australia,
improving immigration compliance in
the workplace**

Department of Immigration and Multicultural Affairs
1999; Canberra.

**Transactions in families :
resolving cultural and generational conflicts**

Papajohn, J.
1995. New Jersey: J. Aronson.

**Women crossing boundaries:
a psychology of immigration and transformations
of sexuality**

Espin, O. 1999. New York: Routledge.

ATMHN Library

Level 2, Bolte Wing
St Vincents Hospital
Nicholson St
Fitzroy

Melbourne

Tel: 03 9411 0310

The ATMHN Library is currently undergoing a few changes. Space (or lack of it) has become a problem and the library will move into a larger area, within the Victorial Psychiatry Unit, at the beginning of March. More space will be allocated for study and a quiet area will be set aside for research purposes.

The Current Contents, a listing of new journals & monographs within the library, is now produced on a bi-monthly basis. If you wish to receive a copy please contact the library. Those who no longer wish to receive this service please contact the library.

ATMHN Website

The upgrade of the Website is continuing, and we are still experiencing a few problems which are currently being addressed. If anyone is having trouble accessing the website please contact Lorraine Stokes on 03 9411 0310 for assistance.

Synergy has gone online! Articles from previous editions of Synergy are now available on the website.

We would like to encourage people to utilise the the What's New section on the homepage. If you have any items of interest to others please email us: v.tittl@medicine.unimelb.edu.au

This month the National Information Service is undertaking a survey of its services, as we feel there are some areas we need to develop more fully. We appreciate your input into the survey.

atmhn.unimelb.edu.au

Postcard from Abroad: Dreams and Realities from the Perspective of the Queensland NESB Community

Jenny Giang, Valentina Dimoska, Ivan Frkovic, Lucia Reguera & Greg Turner

The Queensland Non-English Speaking Background Consumer Advisory Group (NESB CAG) was formed in December 1996 following a public forum in Brisbane attended by a range of consumers, carers, service providers and members of various ethnic communities. The forum provided evidence that NESB people with mental health issues faced many hurdles when seeking and obtaining assistance from mental health services. These difficulties were compounded by the fact that Queensland is relatively sparsely populated across huge distances. The needs of NESB consumers and carers had been recognised by the Queensland Transcultural Mental Health Centre which began in December 1995 and with the formation of the NESB CAG a partnership was formed to work together to transform dreams into reality.

Reality is different for every individual, and culture is only one of the variables that influence the way in which a person views reality. A challenge for the NESB CAG has been to develop mechanisms that can appropriately unearth the realities as viewed by people from various cultures and ethnicities. This challenge is made more difficult through language barriers that can only partly be remedied through the use of interpreters. These challenges are being overcome through the utilisation of an informal approach, which doesn't emphasise the immediate need for group structure, but rather focuses in the early development phase of the group on rapport building and taking time to understand the realities as viewed by various members of the group. This paper explores the challenges faced by Queensland NESB consumers and carers, and the successes they have achieved over the past two and a half years in the pursuit of their dreams.

INTRODUCTION

When people from Non-English Speaking Background, like ourselves, are confronted with mental health issues, we face many hurdles and obstacles. Our dreams and aspirations are to find solutions for relieving the struggles that abound us. This paper explores the challenges faced by Queensland NESB consumers and carers, and the successes they have achieved over the past two and a half years in the pursuit their dreams. Before sharing our story with you, we would like to give you some background information on how the Queensland NESB CAG was formed.

POLICY BACKGROUND

The National Mental Health Policy produced in 1992, states that the quality and effectiveness of mental health services are enhanced if the services are responsive to their consumers and communities. Also, if avenues are created for participation in decision-making about the development of services and about individual's own treatment.

The Queensland Mental Health Policy and Plan and The Ten Year Mental Health Strategy for Queensland, state that consumer, carer and community participation is recognised as one of the best ways of improving health services. It suggests that a framework needs to be developed at central, regional/district and service level to ensure that there is community, carer and consumer participation in planning and monitoring of mental health service delivery.

The Queensland NESB Mental Health Policy Statement, states that NESB representation will be included on the mental health reference and advisory groups wherever possible.

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The Royal Australian and New Zealand College of Psychiatrists 35th Congress

The Royal Australian and New Zealand College of Psychiatrists 35th Congress is to be held at the Convention Centre in Adelaide between the 27th and the 30th April 2000.

The theme of the Congress is "Looking Outward: Culture, Creativity and Psychiatry". We plan to explore the relationship between psychiatric practice and the society in which it is situated.

Indigenous cultures form a core element of contemporary society, both in Australia and New Zealand, and this is reflected in two of the keynote speakers, Dr Lowitja O'Donoghue AC CBE, the distinguished Aboriginal leader, and Dr Erihana Ryan, who has played an outstanding role in Maori health and mental health development.

The Congress will bring an international perspective to this theme, attracting presentations from South Africa, the United Kingdom and North America, including Professor Laurence Kirmayer, a keynote speaker, who has worked extensively with First Nations and Inuit Peoples. The work of the Australian Transcultural Mental Health Network will be highlighted at Congress. The Section is also inviting a range of papers and presentations on varied aspects of transcultural psychiatry. In addition to the keynote speakers, we are privileged to have join us in Adelaide the eminent transcultural psychiatrist, Professor Rosalba Terranova, from the University of Milan, Dr Deji Ayonrinde from The Maudsley, who will be examining the role of ethnic and cultural differences in the therapeutic process, and Dr Leslie Swartz, Director of the Child Guidance Clinic at the University of Cape Town, who brings to the Congress his great experience in working with the Xhosa people.

The theme of the Congress will be developed across a broad range of topics, led by our keynote speakers. Professor Anthony Clare, from Dublin, has a consummate grasp of psychiatry's relation to the wider society, especially the media. Dr Robert Caper, with a background in physics, and now a psychoanalyst who practises in Beverly Hills, brings to the Congress a depth of understanding of phantasy and the dialectic between the inner mind and outer world. Mr Michael White, based in Adelaide, has been one of the most innovative thinkers in the field of narrative, and has worked in collaboration with indigenous people. Dr German Berrios, from Cambridge, combines a powerful scholarship in the history of psychiatry, with a beautifully fine-grained approach to clinical phenomenology. Professor John Strang, at the Maudsley, has extensive clinical and research experience in the field of addictions and comorbidity, notably in the areas of prevention, detoxification, drug transition and opiate overdose.

The choice of keynote speakers reflects our desire to bring the most distinguished Australian and New Zealand authorities in this field into dialogue with their overseas counterparts, and the Congress programme is designed to promote such dialogue, with emphasis on interactive sessions ("meet the expert," "workshops," "master classes").

Registration forms
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For further details,
visit the website:
[http://
www.ranzcp.org/
congress](http://www.ranzcp.org/congress)

In the last three months QTMHC has initiated a number of major projects and developments in the areas of transcultural mental health promotion & prevention, professional development and training, and resource development.

In the area of mental health promotion and illness prevention two projects have been initiated in collaboration with the Brisbane Inner South Division of General Practice and Griffith University, Gold Coast. The first project will pilot an indicated prevention shared care program and the other will develop an anxiety prevention project for young people based on the 'FRIENDS' program'. Both projects have state components funded by Queensland Health and Commonwealth components funded by the Australian Transcultural Mental Health Network. The outcomes produced by both projects will be of national significance and be available for distribution nationally.

In the area of professional development and training, QTMHC is in the process of finalising its train-the trainer program titled Managing Cultural Diversity in Mental Health. The package has been reviewed by interstate and international experts and will be adjusted accordingly before final publishing towards the end of this year. The content of this training package is receiving broader recognition at the tertiary educational level with elements of the package being incorporated into lectures and tutorials in the nursing, social work, occupational therapy, psychology and medical schools. The package is also providing the foundations for the development of a subject in Transcultural Mental Health through the Department of Psychiatry, University of Queensland. In addition to providing ongoing training for public mental health staff, QTMHC is delivering training to general practitioners and developing a course for interpreting in mental health in collaboration Southbank TAFE.

In the area of research, QTMHC is working in partnership with the Youth Affairs Network of Queensland on a needs assessment with young NESB people

experiencing mental health problems such as depression and anxiety. Interviews with young people, their carers and families, and services providers have been conducted in Brisbane, Perth and Adelaide. The project is in the final stages of data analysis and should shed some light on mental health issues affecting young NESB people and their resilience to such problems. QTMHC is also involved in an action research project with Horn of Africa communities and their resettlement issues.

The project is in the data collection phase and should provide some useful information to service providers working with Horn of Africa communities in the resettlement process. Finally, QTMHC has received two reports outlining the mental health needs of the Hmong and Filipino communities in Innisfail, north Queensland. These reports may be of interest to others working with migrant communities in regional and rural locations. For us in Queensland the challenge now is how to work with these communities and local services to meet these identified and documented needs.

In the last three months QTMHC has also produced another package of multilingual

news & views

QTMHC will have a change of leadership with the current manager Ivan Frkovic accepting a six month secondment to the Mental Health Unit in the Corporate Office. Ms Nada Martinek will be the A/Manger at QTMHC during this period.

information titled "Depression is never really 'black or white', some facts about Depression" in thirteen community languages including English. This translation was adapted from information produced by the Mental Health Foundation of Australia. The package contains information on CD for loading onto stand-alone computers and is available from QTMHC for \$100.

If you would like to know more about the program please contact

Greg Turner,
Training Coordinator,
QTMHC, on
Tel: 07 3240 2833, or
email:
greg_turner@health.qld.gov.au

news & views

QTMHC Expands its Professional Development Training Program

On the 9th February QTMHC in partnership with the Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT) conducted a validation workshop for a newly developed draft Train-the-Trainer program. The program, entitled The Need For Understanding: The Care of Refugee Survivors of Torture and Trauma, was researched and written by Chris Lobsinger, counselling Team Leader with QPASTT.

The validation process was developed jointly by Chris and Greg Turner, Training Coordinator with QTMHC. The process involved putting together a group of approximately forty individuals with relevant experience either in working with refugees, clinical experience in Post-Traumatic Stress Disorder, and/or training design and delivery. Each person received a copy of the draft written material and was requested to critically review both the

process and the content of the program, given its intended use as a Train-the-Trainer professional development program. This was followed by a one-day validation workshop facilitated by Chris and Greg and attended by the reviewers. The whole process was very successful with a high degree of validation for Chris' work, with many valuable

contributions and suggestions both on process and content, which will ensure that this program will be of the highest standard.

The program was designed to compliment and become part of the QTMHC professional development program Managing Cultural Diversity in Mental Health, and will be delivered by QTMHC. It is envisaged that the program will become modules 5 & 6 of our existing program, however it will be able to be delivered in stand-alone training sessions to

a range of audiences. Each module is designed to be delivered in an eight-hour training session, however sections within each module will be able to be delivered in shorter sessions, depending on the environment in which they are being utilised.

As with the Managing Cultural Diversity in Mental Health program, the primary target audience for which this program was developed are mental health professionals working within government mental health services in acute inpatient, stand-alone, and community settings. However, others who can demonstrate relevance may also attend training sessions which are appropriate to their positions and their work.

Module 1, "Torture, Trauma, and it's Effects", can be delivered to both clinical and non-clinical service providers working not only in mental health, but across a range of agencies who may work with refugee survivors of torture and trauma. Sections include:

1. Torture and Trauma
2. Refugee Experience
3. Effects of Torture and Trauma
4. Impact of Trauma on Family

Module 2, "Assessment and Treatment", can be delivered to mental health professionals who may have occasion to work with refugee survivors of torture and trauma. Sections include:

1. Assessment and Culture
2. Assessment and Tools
3. Treatment and Recovery
4. The Emotional Responses of Workers

Following the validation process, we now need to synthesise all the comments received and incorporate changes to the draft material to bring it to publication standard. We envisage that the program will be ready for use in professional development in 2001.

Launch of the Directory of Bicultural/Bilingual Mental Health Practitioners, 2000 Edition

Just in time for the new millenium, the 2000 Edition of the Directory of Bicultural/Bilingual Mental Health Practitioners was launched by Professor George Lipton, Chief Psychiatrist & General Manager of the Mental Health Division, in the week before Christmas 1999.

The 2000 Edition is the second edition produced by the Transcultural Psychiatry Unit. The first was published in 1996 and proved to be a useful resource for consumers and practitioners alike. It is timely and appropriate for the Directory to have been reviewed and updated – particularly, in light of the new influx of refugees and migrants resulting from recent conflicts in various parts of the world. These new settlers make up the 'small and emerging communities', whose cultural norms and culture-based conceptualization of mental illness are likely to be relatively unknown to our mental health system but must, nevertheless, be understood and accommodated.

The newly launched Directory contains 110 entries, listing the names and contact details of mental health professionals in the public and private sector. It covers 34 different language groups. By their willingness to be included in the Directory, these

practitioners have indicated that they are prepared to accept referrals of people from culturally and linguistically diverse backgrounds who have a mental health problem. Or, simply to impart cultural advice and knowledge about a given culture to facilitate efficacy of mental health assessment and management of CALD background patients.

It is envisaged that the 2000 Edition of the Directory will continue to be a practical and valuable tool for bringing together, clinicians and consumers who share a common language, and more importantly, a common understanding of culture-based conceptualization and belief systems surrounding mental health and mental illness. These factors underpin the necessary rapport and trust required between the CALD background patient and clinician during the process of mental illness management. The Directory will be updated every two years to ensure it remains relevant.

news
&
views

To obtain copies of the Bicultural/Bilingual Directory, please telephone the WA Transcultural Psychiatry Unit on Tel: 08 9224 1760



From L to R:
Dr Sam Febbo
Head of Unit
Dr Bernadette Wright
Clinical Psychologist
Ms Susanna Calalesina
Project Coordinator for Directory
Professor George Lipton
Chief Psychiatrist &
General Manager
The Mental Health Division,
Health Department WA

news & views

Mission of the National Ethnic Disability Alliance

The National Ethnic Disability Alliance (NEDA) is the peak consumer organization for people from non-English speaking backgrounds with disabilities, including mental health. It is a non-government not-for-profit organization funded by the Commonwealth Government and supported by state based advocacy organizations and individuals.

In brief the mission of the National ethnic Disability Alliance is "to promote and protect the rights of people of non-English speaking background with disabilities, their families and carers".

Due to its cross sector position it is NEDA's role to bring a disability perspective to NESB issues, and a NESB perspective to disability issues. NEDA works across all areas of disability and across all cultural and linguistic groups.

NEDA and its member organizations are actively involved in a wide range of advocacy and project work including:

- Individual and systemic advocacy.
- Submissions to government consultations such as the current Welfare Reform review.
- Development of performance criteria relevant to people from non-English speaking background for a quality assurance system for disability employment services.
- Participation in national projects such as the Partnerships Against Domestic Violence project to develop information resources on domestic violence for women with disabilities.

- Representation on major advisory committees such as Centrelink's "National Multicultural Reference Group" and its "Disability Customer Service Reference Group".
- Working with other organizations such as the Human Rights and Equal Opportunity Commission to develop a paper highlighting human rights issues of concern to people from non-English speaking background with disabilities. It is anticipated that the report will contain references to key research undertaken by the Transcultural Mental Health Network and highlight a number of key issues relating to service provision.
- Working with TCMHN and the Ethnic Mental Health Project (Qld) to establishment of an advocacy organization for non-English speaking background people with disabilities in Queensland.

The National Ethnic Disability Alliance can be contacted on
Tel: (02) 6290 2061.

State based advocacy organizations can be contacted on:

Ethnic Disability Advocacy Centre (WA)
Tel: 08 9221 9921

Action on Disability within Ethnic Communities (Vic)
Tel: 03 9383 5566

Multicultural Advocacy & Liaison Service of SA (SA)
Tel: 08 8346 1488

Multi-Cultural Disability Advocacy Association (NSW)
Tel: 02 9891 6400.

The Carer Information Initiative

The Carer Information Initiative is an exciting program that will see the development of a range of new information resources that will be time relevant and responsive to the individual needs of carers.

A carer is someone who looks after a family member or friend who has a disability, a chronic or mental illness or who is frail and aged. Carers need up to date and relevant information to support them in their caring role. This information must be timely and specific to the needs of the carer. Carer Resource Centres support carers to be well informed and therefore in a better position to make decisions and feel a sense of empowerment. This basic model of community development has grown and developed over the years within our activities and will continue to be the basis of information provision.

The time is right to work together to develop new information resources for carers and that's what is currently happening. Following the evaluation of the existing 'Carer Support Kit' the Department of Health and Aged Care (Carer Support Section) and the Carers Association of Australia (National Carer Resource Centre) have formed a strong partnership to develop new carer information resources.

The Carers Association of Australia has been contracted by the Department of Health and Aged Care to develop the Initiative with a focus on consultation and involvement of the key stakeholders including State and Territory Carers Associations, carers, disability groups, aged

carer organisations and service providers.

How will it all come together?

An overarching Steering Committee has been established to oversee and guide the development of the Initiative, with Working Groups setup to facilitate the work program under the direction of the Steering Committee. The Steering Committee is co-chaired by the Department and the Carers Association. The Committee will comprise members drawn from a diversity of carer interests to provide guidance on the developments of the information resources.

The Working Groups will be time and purpose limited with a fluid membership of people with particular and relevant skills and expertise. There will be a range of Working Groups over the development of the information resources with the initial Groups to be established to include: design; content development; cultural and access; and technology of production and distribution.

The challenge of meeting the needs of all carers will be addressed by the Working Groups and carers will be involved in all aspects of the development of the new information resources. The first stage of the Initiative will involve identifying and developing core information resources that will be of use to all carers.

news & views

Carers and service providers can be involved - for further information please contact

Denise Blayden,
Manager of the National
Carer Resource Centre on
(02) 6288 4877

or visit our website at
<www.carers.asn.au>.

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news & views

Reciprocity in Education Project

The activities of NESBWEB in the last two months have surrounded a number of exciting areas of development in South Australia. One of these has been the planning for the Reciprocity in Education Project, a project recently funded under the ATMHN by joint Commonwealth and State funds.

The Project is a one year pilot activity aimed toward developing a model of interactive learning between a number of NESB communities and mental health care providers. The educational interaction is planned to focus on cultural awareness in mental health as related to depression. The model will be based on principles of reciprocity, social capital and capacity building.

The specific objectives of the Project include:

- To develop a model of reciprocal learning in which:

health care workers learn directly from NESB communities about their specific mental health issues, and their unique culturally based perspectives on mental health

members of NESB communities, including consumers and carers,

learn about mental health by collaborating with health care providers in the planning, evaluation and delivery of mental health care services for their communities;

- To trial this model as a program that elicits and responds to the mental health literacy needs of NESB communities across the life span;
- To focus the project on broad and culturally inclusion definitions of depression;
- To train NESB community workers as community educators
- To strengthen existing partnerships between communities;
- To establish a national reference group to connect the models development with national expertise and development.

NESBWEB has been working to establish the management committee for the project and developing position specifications for the Project Managers position. This will be advertised shortly. The Project has been auspiced by the Adelaide Central Community Health Service which is a regional community health service incorporating many sites and specialist teams.

If you would like to know more about the project contact:

Dr Rob Barrett,
Tel: 08 8222 5141

Ms Rosie Bonnin
Tel: 08 8200 3900

Ms Toni Crisci,
Tel: 08 8130 1300.

VTPU Education & Professional Development Program: Taking stock and looking ahead to 2000 and beyond

Over the last five years the Victorian Transcultural Psychiatry Unit (VTPU) has developed a program primarily for mental health clinicians centred around the relationship of culture, ethnicity and mental health. A number of topics have been researched and developed as teaching modules. These include: culturally sensitive practice, cross-cultural communication, cultural values, migration and settlement issues, working with interpreters, explanatory models of illness, carer and consumer perspectives, cultural constructions of sexuality, transcultural issues in assessment, treatment and counselling. In response to the requests of participants in our sessions all topics may include a special focus on particular groups like the aged, adolescents, women, carers, consumers, international students and indigenous Australians. As a result of the creation and delivery of these programs, and subsequent favourable feedback, other professionals in related fields like welfare and education have also been attracted to relevant programs.

Alongside the development of short programs, we have also been able to offer the above material in greater depth within the Graduate Diploma in Transcultural Mental Health, under the auspices of the University of Melbourne. In fact some 1800 people in all our various programs have availed themselves of these programs over the past five years, the majority being mental health professionals from a range of clinical backgrounds. Some of these report that they are now able to deliver aspects of the programs to their colleagues, which has always been one of our long-term goals.

Currently the Graduate Diploma is being phased out and will likely be replaced with a Master's degree at some future stage. As we have a rich matrix of material collected and developed into subject areas, it would be an exciting new phase to collaborate with universities in other parts of the world using the new technology available for on-line courses...but this is further away. Initiatives to develop on-line material for clinicians'

continuing education in specialist transcultural areas is nearer to hand.

Currently we are turning our attention to extending the established program directed at Area Mental Health Services clinicians Victoria-wide, and focused on local transcultural issues identified and researched by the VTPU. We are also engaged in working partnerships with ethnic mental health consultants, and others like case managers and service managers, who are interested in bringing a transcultural approach to the multicultural workplace, both at general and clinical levels. An example of current collaboration is that with the Early Psychosis Prevention and Intervention Centre (EPPIC) to develop and deliver a workshop on second generation and mental health issues. In addition there will also be a greater emphasis on carer and consumer issues by gathering and presenting salient material in collaboration with representatives from these groups. At the same time we will increasingly turn our attention to ways of reaching ethnically diverse community groups in order to promote community awareness of the factors underlying mental well-being in a new country, and the necessity of greater equity of access to services that should be everyone's birthright.

Other partnerships too are being developed with agencies in the public and private sectors, with ethnic community organisations, with the Resource Unit for Indigenous Mental Health Education & Research (RUIMHER) and with interested educational institutions. These will generate new opportunities for gaining further insight into a broader spectrum of transcultural understanding which will then inform the development of new teaching initiatives. With ten years' experience in the field of transcultural research, education and policy development, the VTPU is poised to take on new directions for a new century.

Diane Gabb
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Professional Development

Victorian Transcultural
Psychiatry Unit

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news
&
views

news & views

Life Promotion Project

The Life Promotion Project, a project established in response to the increasing rates of suicide and 'at risk' behaviour amongst youth in the Northern Territory is continuing.

The purpose of the Life Promotion Project is to establish and consolidate a comprehensive like promotion service and community network as an essential infrastructure to prevent and reduce suicide and its adverse consequences on individuals, families and communities.

The aims of the project are:

1. To heal individuals, families and

communities and empower them to reduce self harm and suicide in their community.

2. To coordinate health promotion strategies through culturally relevant initiatives.
3. To provide options for individuals, families and communities to move to a healthier lifestyle encompassing physical, emotional, spiritual and cultural development.

We'd like to hear from you

The success of such a program is dependent on gaining appropriate comment and feedback from the community. That's why we'd like to hear from you if your family or community has been touched by youth suicide or if you work in this area we invite you to contact us to share your thoughts.

For further information
please contact:

Leonore Hanssens
Life Promotion Officer
Tel: 08 8999 4938

NSW Transcultural Mental Health Centre

Forum on the Mental Health Needs of Men from Culturally and Linguistically Diverse Backgrounds

On the 3rd December 1999 the TMHC, in partnership with Co.As.It, coordinated a Forum on the Mental Health Needs of Men from Culturally and Linguistically Diverse Backgrounds. The aim of the Forum was to provide a venue whereby ideas and strategies could be generated to assist with best practice models, in policy, research and clinical practice, in the area of men's mental health within a culturally and linguistically diverse society.

The morning included presentations by key note speakers on issues on men's health, mental health issues for men from NESB and utilisation of mental health services by men from NESB. A panel discussion was held to assist in further understanding the mental health needs of

men from culturally diverse backgrounds. Participants spent the afternoon in one of five workshops which explored the following areas:

- Mental health issues for men from emerging communities
- Mental health issues for men from established communities
- Mental health needs of younger men from culturally and linguistically diverse communities
- Mental health needs of older men from culturally and linguistically diverse backgrounds
- Migration and settlement issues for men of NESB

Proceedings of the Forum will be available by April 2000.

For further information
please contact

Maria Cassaniti
Tel: 02 9840 3757.

Hearing NESB Consumer Voices Exploring Alternative Methods of Participation

The NSW Mental Health Consumer Action Group has begun to focus its energies on exploring alternative ways of NESB consumers participating to ensure that vital viewpoints are heard within the group that may be drowned out through formal participation process such as committee work; personal consumer education due to barriers, cultural inappropriateness etc.

An exciting initiative was presented at the Fifth Transcultural Mental Health Conference. The Consumer Action Group held a poetry performance that was inspired by paintings from an independent NESB consumer artist that has collaborated with the group. Asaad Cina a MHCAG group member feels more comfortable expressing his views through poetry as he was an accomplished poet of his native country Afghanistan. He writes the poetry in Persian and then it is translated into English for all the group to enjoy and further broaden its understanding of NESB consumer issues.

He has written many poems on his experiences in Afghanistan from a consumer perspective and the group would like to share one to provide Synergy readers with an inspiration for delving into divergent methods of involving consumers in articulation of their experiences.

Here is a taste of one of Asaad's poems that illuminates the experiences of a country being invaded and the ravaging effects on both the land and its people. In an interview with me, Assad describes the poem in this way;

"Last summer in one of the valleys in Afghanistan when the enemy took the valley they started forcing the innocent people to leave their own homes and their valleys.

They started torturing people and children, men and women burning and destroying their houses, their gardens and their valley. As a result thousands and thousands fled and journeyed through the night and almost 25 000 innocent people were moved by the enemy to other parts of Afghanistan which were occupied".

MHCAG will endeavor to raise funding to further explore alternative methods of NESB consumer participation and a space for diverse voices to be heard. A possibility is further collaborating on our work with consumer artists, poets and musicians and running a workshop with interested participants in exploring how one medium of art can inspire a person from a completely different culture to identify and articulate their own narrative in whichever form they most feel comfortable.

The consumer exhibition held at the Conference will be the first step in exploring the process undertaken by 2 consumers with varying experiences to find common ground and understanding through individual mediums of work. It also allows us to reflect that NESB consumers have much to teach other consumers and that the traditional modes of participation may be inappropriate. Experimentation, creativity and flexibility will allow hidden voices to be heard.

Vicki Katsifis
NSW TMHC
Consumer Project Officer

news
&
views

JOURNEY THROUGH THE NIGHT

A poem written by Asaad Cîna in Persian
translated into English

In the cold, early morning of a winter night
With the fright of death in my heart
We move softly through the cold/dark glacial journey
With silence on our lips
With the sweet smell of hope, and eyes filled with tears
With no hope for the future and the darkness
Of unavoidable bullets, taking my pain
Running away from the hour of the dark monster of a wind force
I leave my home, my country
Going past mountains and deserts with heartache and pain,
Dragging my feet through the darkness of the night
My journey through the night
I was led towards the unknown
Glass, journey of glasses through the rough mountains,
Journey to the unknown
Infants innocent, clear like glass, and
Vulnerable bodies moving through
Victims of enemies hiding away, targets of mass killings,
Breaking of glass
The cry of breaking glass in the journey of the night
As the earth moves,
As the people move,
The impact of breaths moving up and down
The light illuminates the glass, through the night
Glass breaks; people die, bullets are shot
Mass killing of glass in the mountains
The cry, the breakage, fills the sky and air,
Of the journey through the night
Though I have survived the horror

BOOK REVIEW:

MENTAL HEALTH CONSUMER PARTICIPATION IN A CULTURALLY DIVERSE SOCIETY

A decade ago Minas (1988) argued that the involvement of ethnic communities in the planning, provision, management and evaluation of services was minimal or non-existent. Minas, Silove and Kunst (1993) later highlighted the lack of adequate structures and processes for genuine participation by NESB communities in the design and evaluation of services as one of the deficiencies in the current environment that impinged on NESB mental health issues.

It is often thought that providing equal opportunities for participation simply entails treating people identically or providing exactly the same type of participation initiative in which everyone can be involved. Treating people equally, however, often requires developing participation initiatives that are tailored around individuals' or communities differing needs.

The monograph *Mental health consumer participation in a culturally diverse society* explores the changing landscape of

The monograph qualitatively examines participation models and strategies that have successfully engaged consumers, carers and community members in partnership to develop, manage and evaluate services. It details at the length the experiences of consumers, carers and staff across four themes:

- i. The understanding of partnerships;
- ii. Success in achieving genuine partnerships;
- iii. Facilitators and barriers to participation;
- iv. Issues of representativeness.

In addition to examining current participation initiatives in Australia, this monograph explores some of the critical lessons that have emerged from the international literature on consumer and community participation. The authors identify an array of possibilities for participation and explore avenues by which readers can create strategies that suit their needs.

This monograph is an essential resource for mental health consumers, carers, community members, mental health and community health service providers and managers, and policy makers and planners.

It will also be of value to people who are interested in improving the quality of mental health and community health services for disadvantaged and marginalised groups and for developing consumer participation and partnerships generally.

This monograph was produced as part of the Specific Project Program of the Australian Transcultural Mental Health Network under the National Mental Health Strategy.

'This report contains some real gems a couple of which I have already incorporated into my own daily practical work'

Gwen Scotman, NSW Delegate and Deputy Chair Australian Mental Health Consumer

participation involving culturally and linguistically diverse communities and the current structures and processes, successfully implemented by eight organisations around Australia, that actively encourage and support participation and partnerships.

**For further information about the monograph please contact the Australian Transcultural Mental Health Network on;
Tel: (02) 9840 3333**

CULTURE, HEALTH & ILLNESS

The University of New South Wales Faculty of Medicine has announced a new course available to health workers, educators, researchers and policy makers.

Culture, Health & Illness will focus on the study of health and illness in the setting of multicultural Australia and developing countries in the Asia Pacific region. You will learn about theories and methods of relevant disciplines (like medical anthropology, transcultural psychiatry); about cultural aspects of international health, and health within culturally pluralistic societies.

Each week, a central issue of culture and health will be considered. The first hour of each session will focus on the Australian multicultural context, with examples taken from medical practice and the social context of health among immigrant and culturally diverse communities. The second hour will apply these principles to the same health development issues in developing countries.

For further information please call: 02 9385 2500

CULTURAL COMPETENCE IN VICTORIA

Examination of the interaction between the stress and risk factors associated with migration, and their impact on mental health, is essential to understand the mental health needs of immigrants undergoing adjustment to their new country. A significant part of addressing mental health needs of CALD immigrants is to provide culturally appropriate mental health promotion. Community settlement services workers assist newly arrived migrants and refugees, and it is important to develop a partnership with them and to provide them with the opportunity to increase their knowledge and understanding of mental health issues.

In assessing mental health training needs, developing, delivering and evaluating mental health training for CSS workers, this Eastern Perth Public and Community Health Unit project aimed to increase mental health promotion and prevention activities relating to communities and people of culturally and linguistically diverse backgrounds. It was developed through the collaboration with WA TPU clinical psychologist and assisted by members of the steering committee. The objectives were to increase CSS workers' competence to promote emotional and social well-being among their client groups and to create an environment supportive to CSS workers promoting social and emotional well-being among CALD communities.

The project developed from workshops for CALD communities and the need to establish effective and efficient mental health information dissemination. CSS workers in WA were sent questionnaires resulting in a seventy percent response rate. Based on the needs assessment and agency consultations, a mental health training package was developed and delivered to CSS workers by mental health

professionals from Perth North Metropolitan Health Service, WA Association for Services to Torture and Trauma Survivors and Graylands Hospital. Based on the topics chosen for inclusion in the training package, an information kit was compiled to assist CSS workers when dealing with mental health related issues. State transcultural mental health centres and torture and trauma rehabilitation services were consulted, as recommended in the Mental Health Promotion and Prevention National Action Plan (1999), in the process of mental health training development and collecting social and emotional well being related information for the information kit.

The training was evaluated to assist with any revision. The training evaluated very well. The CSS workers found this training would assist them to better understand their clients' needs, particularly the cultural issues associated with experiencing a mental illness. By being better informed, CSS workers should be able to serve their clients better and to influence existing mainstream services to provide more culturally sensitive services.

The recommendations generated by the findings of the needs assessment were collected in the Report of the Community Settlement Services Worker's Mental Health Promotion and Training Needs Assessment. The report was launched by WA Department of Immigration and Multicultural Affairs Deputy Director, Ms Paula Kansky. ■

For further information please contact:

Ms Renata Kokanovic

renakoka@rph.health.wa.gov.au

Tel: (08) 9224 1347

Fax: (08) 9224 1612

The final question was about the ethnic group with whom each parent identified. The results of this survey were analysed by the VTPU. A major finding was that approximately 26.8% of the children and adolescents referred to CAMHS during the survey period were either born in a non-English speaking country themselves (6.4%) or had one (10.5%) or both parents (9.4%) born in a non-English speaking country. The city CAMHS, where most of the CALD communities reside, wish to continue collecting this information and discussions are underway to consider how this can be organised.

RESOURCE MANUAL

The Project Officer has collated a Resource Manual for CAMHS workers. This comprises:

- a directory listing the names, addresses and phone numbers of the main ethno-generic and ethno-specific services as well as those mainstream services which have been able to respond effectively to CALD children, young people and their families;
- policy documents and other resources developed by NGO; Federal and State Governments;
- journals and newsletters which focus on ethnic issues; videos and a C D Rom with information relevant to providing culturally sensitive therapeutic practice;
- a comprehensive list of books and articles written for mental health clinicians about cross-cultural therapeutic interventions.

This Resource Manual will appear in hard copy and on the ATHMN website.

STRATEGIC PLANS

The final responsibility of each CAMHS towards the Project is the development of a strategic plan to

guide their development of cultural competence. Initially it was anticipated that this document could also be developed within the year, but it is now clear that this Project goal was unrealistic. Some CAMHS have produced a first draft. Others are still working on one.

FINAL REPORT

The final report will describe the structures; processes and outcomes of the Project; the role played by the Steering Group in guiding this process; that played by the Austin and Repatriation Medical Centre and in particular the MHPO in the management of the Project; what was learnt in the process of conducting the Project and the recommendations arising from it. In particular, there will be comments about the training needs of CAMHS clinicians both with respect to working with CALD communities and to do with culturally therapeutic clinical interventions. ■

Reference

Luntz, J. J., (1998), Cultural Competence in CAMHS: Report on the usage of Child and Adolescent Mental Health Services by Adolescents and their Families.

1. *At the commencement of this project the acronym still in common use in Victoria was NESB. CALD is now becoming more common. The article has used both terms.*

Continued from page 7

POSTCARD FROM ABROAD: DREAMS AND REALITIES

The Queensland Transcultural Mental Health Centre in collaboration with the Ethnic Mental Health Program, and other Ethnic Mental Health Service Providers, worked towards the establishment of a NESB Mental Health Consumer and Carer Advisory Group in line with the above policy framework. In December 1996, following a public forum, the Queensland NESB CAG was formed.

BARRIERS FACED BY NESB PEOPLE WHEN ACCESSING MENTAL HEALTH SERVICES

CASE EXAMPLE

An overseas born young woman of Chinese origin was admitted to hospital for the first time at the age of sixteen. Conflict occurred between the medical professionals and the carers, namely the parents, concerning the delivery of treatment. The carers were overwhelmed and frightened by the side effects, resulting from the administration of conventional western medicine. Under extreme emotional distress and in a state of confusion, their immediate response was to have their child discharged from the hospital and to discontinue the intake of drugs. The carers then engaged in an alternative form of medicine, a treatment of which they have more knowledge.

This case illustrates the diversity of mental health knowledge and how it can create problems when there are conflicting beliefs, ideas and customs. Thus, there is a need to appreciate, understand and respect the values of one another's culture. The literature highlights the point that people from NESB who have mental health problems have specific religious, cultural and language needs which must be addressed by services to ensure appropriate care (Cauchi, 1991 & Fitzgerald, 1996).

Perhaps, more ideally, there is a need to integrate the various ethnic groups, in pursuit of the formulation for an international/global perspective of the term, "mental health". Including such items as religious, spiritual and social customs into clinical training may help mental health services remain relevant and culturally sensitive to consumers, carers and community members of NESB. Furthermore, there is a need to extend and to incorporate this knowledge and education into schools' syllabus as the onset of a mental illness can and does occur at a young age (as evident from the case example).

Additional information on mental health and relating issues can also be included in the immigration package.

Hurdles faced by NESB people include trying to understand the infrastructure of the mental health system, especially, when it is their first encounter with an unfamiliar environment. Furthermore, understanding the procedures/operations of the system structure and where to seek information on relevant services. For instance, how do NESB people become aware of facilities such as transcultural services and ethnic mental health programs? In addition, where can NESB people gain access to these service providers? Overall, factors such as lack of information, styles and techniques of interactions, and lack of knowledge can create difficulties for NESB people in securing access to services. Perhaps, flexibility within the system should be considered when NESB people are involved.

These hurdles are made more difficult due to the fact that Queensland is relatively sparsely populated across huge distances. Under this condition, is there an availability of appropriate services for NESB people living in remote areas? What necessary mechanisms are required to accommodate NESB people who are not living in the metropolitan area or within a close distance? This issue needs to be addressed and investigated.

Above all, language barriers impose the most difficulties for NESB people whilst seeking and obtaining assistance from mental health services. More specifically, language barriers prevent effective communication with medical professionals. Although the majority of the NESB population can speak English well in everyday situations, English proficiency is commonly reported to deteriorate with emotional and psychological distress (Sozomenou, 1999). Thus, the availability of professional interpreters and bilingual staff are essential during

Continued overleaf

Synergy Autumn 2000

these interactions. Unfortunately, there is evidence that these resources are both scarce and poorly utilised (Minas, Stuart and Klimidis, 1994). This is even more the case in remote and rural Queensland.

To resolve the struggle and thus, to pursue the dreams of NESB consumers and carers in Queensland, a NESB CAG partnership was formed with the Queensland Transcultural Mental Health Centre and in the latter, with the Ethnic Mental Health Program. The Queensland NESB CAG comprised members who represent different ethnic groups. This composition is unlike other NESB CAGS where they have separate CAGS for each ethnic group and then a member from each ethnic group is selected to become a representative in the central NESB CAG. The QLD NESB CAG did not duplicate this approach but adapted an approach that captured and accommodated the unique needs of the NESB community in Queensland.

EARLY DEVELOPMENT PHASE OF NESB CAG

In the early development phase of NESB CAG, the group focussed on rapport building and provided the opportunity to share and to understand the realities as viewed by various members of the group. Meetings followed an informal approach, thereby creating a friendly and open environment where members are encouraged to express their concerns. The strength of the group results from each member bringing along skills from his or her own culture, and also their individual skills. A unique NESB CAG mechanism was the involvement of support workers whom act as members' language aid during the meetings, and also provide general support and mode of transport where needed.

The meetings of NESB CAG are structured in such a manner where members are given adequate time to

have information interpreted for them and to subsequently absorb and process the information. Overall, the main task of this phase was to develop a sense of belonging to the group and to promote the exchange of ideas among NESB members. However, the group was also able to channel these ideas through to other CAGS, to Queensland Consumer and Carer Advisory Group (QCAG) and to mental health service providers. This communication to groups outside of NESB CAG was achieved through a NESB representative on QCAG who shared information with other NESB consumers and carers, and also included concerns and issues of the NESB Group on the QCAG agenda.

One of the aims of the group during this stage of development was to increase NESB representation on QCAG and local CAGS. Therefore, it was necessary that the consumers and carers be trained and up-skilled in relation to the overall National and State Mental Health Policy and service framework, the Queensland NESB Mental Health Policy Statement and the roles, structure and resourcing of the various Mental Health Services. Thus, in building the knowledge and confidence of NESB consumers and carers we hope to increase the likelihood that they become representatives in other district CAGS and QCAG.

SECONDARY DEVELOPMENT PHASE

In an attempt to develop mechanisms that can appropriately unearth the realities as viewed by people from various cultures and ethnicities and to consolidate the commitment and the spirit of members, the group decided to hold its first planning day. An experienced training coordinator from QTMHC facilitated the planning day. The outcome of the planning day revealed the importance for the group to develop a secure foundation and to formulate a structure. Firstly, in order to strengthen the effectiveness and knowledge of the group, it was decided

that the 'Kit' would be utilised as a source of reference and that the group would work on the Kit by setting aside time at each regular meeting. Secondly, the group proceeded to elect members to fulfil the positions of Chairperson, Deputy Chairperson, Secretary and Treasurer. In addition, the group plans to set up a rotation system where the Chair, the Treasurer and the Secretary, each having a deputy with whom they develop a "buddy" system and coached them to take the position at the next election or change over. Once structure was developed, the next factor to consider was to determine how to manage meetings effectively. It was suggested by the training coordinator from QTMHC to locate an external process facilitator.

It follows that the mission and objectives of the group are now formally owned by the group's new position of knowledge and purpose. Members want to raise awareness within the community concerning mental health issues of NESB consumers and carers and to inform Service Providers in facilitating the development and delivery of culturally appropriate services that meet the needs of NESB people. Thus, the group is entering new territory and accepts this challenge so that the dreams will be realised. In addition to the continuing partnership with the QTMHC, the EMHP has joined the team to assist NESB people to transfer their dreams into reality.

CONCLUSION

The Queensland NESB CAG has progressed and developed to a stage where they are more effective in making valuable contributions to the development and delivery of mental health services for NESB people. However, even at this stage, the group needs support, training, evaluation and adequate resourcing, to ensure successful consumer and carer participation. Nevertheless, dreams and realities are with us now and are here to stay! ■

Events Calendar

April

1-3

Suicide Prevention:

Everybody's Business

Seventh Annual Conference of Suicide Prevention Australia

Melbourne Convention Centre, Victoria
Suicide Prevention Australia

Tel: 02 9211 1788

27-30

Looking Outward

Culture, Creativity & Psychiatry

The Royal Australian & New Zealand
College of Psychiatrists 35th Annual
Congress

Adelaide Convention Centre, SA
Australian Convention and Travel Services
Tel: 02 6257 3299

May

4-6

Getting it Right!

A National Conference on Anxiety Disorders & Co-Existing Conditions

Obsessive Disorder/Triumph over Phobia
Management Committee of the NSW Assoc.
for Mental Health

Manly Pacific Park Royal, Sydney
Conference Action
Tel: 02 9956 8333
Email: Contact@conferenceaction.com

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Youth Health Forum

Integrating School & Health

The Centre for the Advancement of
Adolescent Health

The New Children's Hospital
Westmead, Sydney
Tel: 02 9845 3338

June

25-28

Resiliency- Successful Connections

International Association for Adolescent
Health 3rd Pacific Rim Conference

Lincoln University Campus
Christchurch, New Zealand
Email: obric1@publichealth.co.nz

July

15-16

Our Lives Our Choices

Australasian Consumer Run Mental Health
Conference

Adelaide, South Australia
Tel: 08 8373 2063

27-28

Bridging Our Worlds

VICSERV 2000 Conference

Caulfield Racecourse, Melbourne
email: conf@vicserv.org.au

August

2-3

Health Outcomes for the Nation:

Best Bets and Best Buys

6th Annual International Health Outcomes
Conference 2000

Rydges Lakeside, Canberra
Australian Health Outcomes Collaboration
Tel: 02 6205 0869
Email: jansan@atrax.net.au

28-31

Creativity & Development:

Services for the Future

10th Annual TheMHS Conference

Adelaide Convention Centre, South Australia
Tel: 02 9926 6057

2001

May

13-17

Yes to Life! No to Violence

7th IAAH Congress

Salvador Brazil
email: tonkiaah@islandnet.com

28-30

Diversity in Health:

Sharing Global Perspectives:

2nd ATMHN Conference
3rd Australian Multicultural Health Conference
6th NSW TMHC Conference

Darling Harbour, Sydney
Conference Secretariat
Tel: 02 9518 9580
Email: diversity@pharmaevents.com.au

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Contributions to this
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Australian Capital Territory

ACT Transcultural Mental
Health Network (02) 6205 1608
Health Outcomes, Policy & Planning,
Department of Health & Community Care (02) 6205 0877

Commonwealth

Department of Health & Aged Care,
Mental Health Branch (02) 6289 7722

Community / Consumer / Carer Associations

Australian Mental Health Consumers Network (07) 3394 4852
Carers Association of Australian Inc (02) 6288 4877
Federation of Ethnic Communities
Councils of Australia Inc. (02) 6282 5755
Mental Health Council of Australia Inc. (02) 6285 3100
National Ethnic Disability Alliance (02) 6290 2061

New South Wales

Mental Health Branch, NSW Department of Health (02) 9391 9299
NSW Transcultural Mental Health Centre (02) 9840 3800

Northern Territory

Mental Health, Aged & Disability Services,
Territory Health Services (08) 8999 2916

Queensland

Mental Health Unit, Queensland Health (07) 3234 0674
QLD Transcultural Mental Health Centre (07) 3240 2833

South Australia

Mental Health Unit,
SA Department of Human Services (08) 8226 6275
SA Transcultural Mental Health Network (08) 8222 5141

Tasmania

Mental Health Program, Department
of Health & Human Services (03) 6233 4750

Victoria

Aged, Community & Mental Health,
Department of Human Services (03) 9616 8123
Victorian Transcultural Psychiatry Unit (03) 9417 4300

Western Australia

Mental Health Division,
Health Department of Western Australia (08) 9222 4099
WA Transcultural Psychiatry Program (08) 9224 1760

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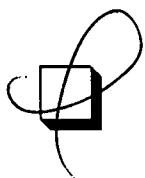


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